

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 49-31

CERTIFICATE OF DEATH

Reg. Dist. No. 09600 4

DR. HODGES

1. PLACE OF DEATH:

County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 yrs
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 69 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
Street No. 19 PULMAN ST.
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME

M.
ELIZABETH BARNES
4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, married, widowed, or divorced MARRIED
6. (b) Name of husband or wife ALFRED BARNES
6. (c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) MARCH 14, 1906
8. AGE: Years 40 Months 7 Days 7 If less than one day
.....hrs.min.

9. Birthplace MARYLAND
(Town, county, and state)

10. Usual occupation HOUSE WIFE

11. Industry or business

12. Name WILLIAM CRUTHERS

13. Birthplace MARYLAND

14. Maiden name ELIZABETH Light

15. Birthplace MARYLAND

16. Informant MEMORIAL HOSPITAL

Address CUMBERLAND, MARYLAND

17. Burial Date thereof 10-24-46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cem.

Location Cumberland

18. Funeral director Louis Stein Inc.

Address Cumberland

19. Oct. 23, 1946 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH OCT. 21, 1946 at 4:05 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 13, 1946 to Oct. 21, 1946
and that I last saw him alive on Oct. 21, 1946

Immediate cause of death Abdominal Carcinomatosis
Due to Primary carcinoma of stomach
Due to P. a. g. a.
Other conditions

(Include pregnancy within 8 months of death)
Major findings of operations Generalized Carcinomatosis Date of op. Aug. '46
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur?
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. R. Hodges, M.D. M. D. or other
Cumberland Md Date signed 10/21/46
Address

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

11 N. Charles St., Baltimore



09601

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County AlleghenyCity or town Pennsboro
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 dayHospital, institution, or street address where death occurred: Allegheny HospitalHow long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleghenyCity or town Pennsboro
(If outside city or town limits, write RURAL and give nearest town)Street No. Road 220

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Cora Elizabeth Barton

3. (b) Social Security Number

None4. Sex Female5. Color or race White6. (a) Single, married, or divorced Married6. (b) Name of husband or wife Geo W Barton7. Birth date of deceased (mo., day, yr.) Nov 20, 1887

6. (c) If alive, give age years

8. AGE: Years 58 Months 10 Days 26 If less than one day hrs. min.9. Birthplace Ind.
(Town, county, and state)10. Usual occupation Housewife11. Industry or business At Home12. Name Henry Snyder13. Birthplace Germany14. Maiden name Maria Bowman15. Birthplace Ind.16. Informant George W BartonAddress Pennsboro Ind.17. Burial (Burial, cremation, or removal, which?) Burial Date thereof Oct 18, 46
(month) (day) (year)Cemetery or crematory St Ambrose CemaLocation Leesportown Ind18. Funeral director Louis Stein IncAddress Leesportown Ind19. Oct 18, 46 Registrar J. P. Frankel M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 16, 1946 at 6:50 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 1, 1946 to October 16, 1946and that I last saw him alive on October 15, 1946Immediate cause of death pulmonary embolismDue to phlebitis left lower legDue to varicose veins

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations nothing removed from left wrist 10-1-46Date of op. 10-1-46

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L. Stein M.D.Address 59 Green St. M. D. or otherDate signed 10-16-46

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

OCT 22 1946

BUREAU V B

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131-22

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County... Allegany
City or town... Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

R.D.# 2, Winifred Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... AlleganyCity or town... Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. R.D.# 2, Winifred Road
(If rural, give LOCATION)

2.(a) If veteran, name war...

3. (a) FULL NAME

William Edward Brakeall

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

DivorcedB. (b) Name of husband or wife... Mary Morse

6. (c) If alive, give age... years

7. Birth date of

deceased (mo., day, yr.)

Sept. 15, 1874

8. AGE:

Years

72

Months

0

Days

28

If less than one day

hrs. min.

9. Birthplace... Warfordsburg, Pa.

(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

Carman B.&O. R.R.Co.

FATHER

12. Name

George Brakeall

13. Birthplace

Penna.

MOTHER

14. Maiden name

Mary Ramsburgh

15. Birthplace

Maryland

18. Informant

Mrs. Frank Lizer

Address

R.D.#2 Cumberland, Md.

17.

Burial

(Burial, cremation, or removal. Which?)

Date thereof

Oct. 16, 1946

(month) (day) (year)

Cemetery or crematory

Tonoloway Baptist Cem.

Location

Near Warfordsburg, Penna.

18. Funeral director

Charles L. George

Address

Cumberland, Md.

19.

Oct. 15, 1946
(Date rec'd by registrar)

19.

J. P. Franklin M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... Oct. 13, 1946, at... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct. 13, 1946, to Oct. 13, 1946
and that I last saw him... alive on not at all, 19...

Immediate cause of death

Coronary thrombosis

DURATION

Due to

Organic heart disease

Due to

Myocarditis, chronic interstitial

Other conditions

Duration: 3 years

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Heart failure Injured at work?

23. SIGNATURE

Thos H. ...

M. D. or other

Address

Cumberland MdDate signed 21-3

RECEIVED
OCT 22 1946
BUREAU U.S.

2411 N. Charles St., Baltimore 1642

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County... Allegany
 City or town... Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?... 2 months
 Hospital, institution, or street address where death occurred:
815 Manns Terrace
 How long in hospital or institution?...

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... Md County... Allegany
 City or town... Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No... 815 Manns Terrace
 (If rural, give LOCATION)
 2.(a) If veteran, name war...

3. (a) FULL NAME

George Edward Brown

3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

MWMarried6. (b) Name of husband or wife... Katherine Brown8. (c) If alive, give age... 59 years7. Birth date of deceased (mo., day, yr.)... January 10, 1887

8. AGE: Years Months Days If less than one day

59829

hrs.

min.

9. Birthplace... Sykesville, Carroll, Maryland
(Town, county, and state)10. Usual occupation... Elevator construction11. Industry or business... U.S. Government12. Name... Saib Brown13. Birthplace... Sykesville, Maryland14. Maiden name... Lucille Welch15. Birthplace... Sykesville, Maryland16. Informant... Mrs. Katherine BrownAddress... 815 Manns Terrace17. Burial Date thereof... October 13, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory... Allegany CemeteryLocation... Frostburg, Md18. Funeral director... J. P. FranklinAddress... Cumberland, Md19. Oct. 12, 1946 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... Oct. 9 19... 46, at... about 2 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from... 19... to... 19... and that I last saw him... Dead Oct. 9 19... 46Immediate cause of death... Strangulation DURATION... At onceDue to... hanging

Due to...

Other conditions...

(Include pregnancy within 3 months of death)

Major findings of operations...

Date of op...

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Suicide Date of... 10.9.46Where did injury occur? Cumberland Allegany Md.
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) Tool house rear
Means of injury hanging 815 Manns Terrace
Injured at work?23. SIGNATURE... H.V. Deming M.D. H.V. Deming M.D.
M. D. or otherAddress... Cumberland Md Date signed... 10-10-46Deputy Medical Examiner - Allegany Oct

MARGIN RESERVED FOR BINDING

VS A15

9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED TO GENERAL INVESTIGATIVE DIVISION

RECEIVED TO GENERAL INVESTIGATIVE DIVISION

RECEIVED

OCT 15 1946

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-a

09604

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH:

County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 28 yrs

Hospital, institution, or street address where death occurred:

825 Windsor Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 825 Windsor Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Lena Bell Catherman

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband

Charles S Catherman

7. Birth date of deceased (mo., day, yr.)

Nov. 15 1877

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

681112

hrs.

min.

9. Birthplace

Clarkson, Ohio
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

at home

FATHER

12. Name

Joseph B. Bell

13. Birthplace

Ohio

MOTHER

14. Maiden name

Elizabeth Johnston

15. Birthplace

Ohio

16. Informant

Chas. S. Catherman

Address

Cumberland

17. Burial

Burial

Date thereof

Oct 29 '46
(month) (day) (year)

Cemetery or crematory

Willcrest Cem.

Location

Cumberland

18. Funeral director

Louis Stein Inc.

Address

Cumberland

19. Oct. 29

1946J. P. Franklin, M.D.Registrar(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct 27 1946, at 5 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 27 1946 to July 30 1946and that I last saw him alive on Sept 15 1946

Immediate cause of death

Cerebral Hemorrhage

Due to

Hypertension

Due to

Hypertension

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

C. L. Owens M.D.Address Cumberland MdDate signed 10-29-46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2-35-

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 09605

1. PLACE OF DEATH:

County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 27 years

Hospital, institution, or street address where death occurred:

233 Henderson Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 233 Henderson Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Sallie Ann Chedester

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife Thomas Chedester7. Birth date of deceased (mo., day, yr.) Aug 19, 1885

6. (c) If alive, give age years

8. AGE: Years 61 Months 1 Days 27 If less than one day
hrs. min.9. Birthplace Riverton, Pendleton Co., W. Va.
(Town, county, and state)10. Usual occupation Housework11. Industry or business at home12. Name John Thompson13. Birthplace Riverton W. Va.14. Maiden name Jennie Raines15. Birthplace Riverton W. Va.16. Informant Alvis ChedesterAddress 233 Henderson Ave - Cumberland17. Burial Date thereof Oct. 19, 1946
(Burial, cremation, or removal Which?) (month) (day) (year)Cemetery or crematory Hillcrest CemeteryLocation Cumberland, Md.18. Funeral director John J. HaferAddress Cumberland, Md.19. Oct. 18, 1946 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 16, 1946 at 5:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 13, 1944 to Oct 16, 1946and that I last saw her alive on Oct 15, 1946

Immediate cause of death

Carcinoma ofDue to uterusOther conditions generalvaricella

(Include pregnancy within 3 months of death)

Major findings of operations Carcinoma of uterusDate of op. 1944

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE P. L. Owens, M.D.Address Cumberland, Md. Date signed Oct 17-46

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

OCT 22 1946

BUREAU V 8

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

88-a

09606

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County AlleghenyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 80-11-25

Hospital, institution, or street address where death occurred:

Memorial HospitalHow long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleghenyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 1036 Bedford St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed6.(b) Name of husband or wife Louisa Bachman7. Birth date of deceased (mo., day, yr.) Nov 16 1865 6.(c) If alive, give age _____ years8. AGE: Years 80 Months 11 Days 25 If less than one day _____ hrs. _____ min.9. Birthplace Cumberland Ind.
(Town, county, and state)10. Usual occupation Painting Contractor

11. Industry or business

12. Name Louis R. Danner13. Birthplace Ind.14. Maiden name Mary Dr. Easter15. Birthplace Ind.16. Informant Miss Emma C. DannerAddress Cumberland17. Burial Date thereof Oct 14 46
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Hillcrest Cem.Location Cumberland18. Funeral director Louis Stein Inc.Address Cumberland19. Oct 14 19 46 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 11 19 46 at 4 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/2/46 19 to 10/11/46 19
and that I last saw him alive on 10/11/46 19

Immediate cause of death

DURATION

Cerebral Hemorrhage
Due toArteriosclerosis
Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. Williams, M.D. M. D. or otherAddress Med. Bldg Date signed 10/12/46

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

OCT 22 1945

BUREAU

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

CERTIFICATE OF DEATH

★ 09607 40
Reg. Dist. No.

MARGIN RESERVED FOR BINDING

VS A15 9.45.15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 yrs
Hospital, institution, or street address where death occurred:
415 Pulaski St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MD County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 415 Pulaski St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Sallie Caldwell Dean
3. (b) Social Security Number None

4. Sex Female
5. Color or race white
6. (a) Single, married, widowed, or divorced widow
6. (b) Name of husband or wife George W. Dean
6. (c) If alive, give age _____ years
7. Birth date of deceased (mo., day, yr.) Mar 22 - 1863
8. AGE: Years 83 Months 7 Days 5 If less than one day _____ hrs. _____ min.

9. Birthplace Carlisle, Penna.
(Town, county, and state)
10. Usual occupation Home
11. Industry or business "
12. Name William S. Weigert
13. Birthplace Penna.
14. Maiden name Mary Frost
15. Birthplace Penna.

16. Informant Ronald C. Dean
Address 415 Pulaski St.
17. Burial Date thereof Oct 30, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Benificial Cemetery
Location Cumberland, Md.
18. Funeral director John J. Hofer
Address Cumberland, Md.
19. Oct. 30 19 46 J. P. Faulkner, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION
20. DATE OF DEATH Oct 27 19 46 at 9:30 P.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 27 19 46 to Oct. 27 19 46
and that I last saw him alive on Oct. 27 19 46
Immediate cause of death Cerebral hemorrhage
DURATION 1 hour
Due to Cerebral hemorrhage
Due to _____
Other conditions _____
(Include pregnancy within 8 months of death)
Major findings of operations _____ Date of op. _____
Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____
Where did injury occur? _____ (City or town) _____ (County) _____ (State)
Injured at home, farm, industry, public place (where?) _____
Means of injury _____ Injured at work? _____
23. SIGNATURE W. C. Dean
26 Wm. H. Cumberland M. D. or other _____
Address _____ Date signed 10/28/46

RECEIVED
NOV 6 1946
BUREAU V.A.

2-35-

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1700

CERTIFICATE OF DEATH

Reg. Dist. No. 8

1. PLACE OF DEATH:

County Allegany
 City or town Near Cumberland
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution or street address where death occurred:

State Hwy
 How long in hospital or institution?

3. (a) FULL NAME

John Kenneth Dixon

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Married

6. (b) Name of husband or wife Nesta Millison7. Birth date of deceased (mo., day, yr.) Sept 10 - 1908 8. (c) If alive, give age years

8. AGE: Years 38 Months 1 Days 3 If less than one day
 hrs. min.

9. Birthplace Cumberland Ind
(Town, county, and state)10. Usual occupation Chaffer11. Industry or business Truck12. Name John Ken Dixon13. Birthplace Pa.14. Maiden name Emig Wolford15. Birthplace Chesa Dixon16. Informant CumbrlandAddress Brual17. (Burial, cremation, or removal, Which?) Brual Date thereof Oct 16 46
(month) (day) (year)Cemetery or crematory John Brown Cem.Location Near Cumberland18. Funeral director Louis Stein IncAddress Cumbrland19. Oct. 17 19 46 Jannette M. Boal
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Cumbrland
(If outside city or town limits, write RURAL and give nearest town)Street No. 221 Davidson St.
(If rural, give LOCATION)2. (a) If veteran, name war World War II

3. (b) Social Security Number

214-05-6028

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 13 1946 19 46, at 7.30A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19. and that I last saw him Dead Oct. 13 19 46

Immediate cause of death

Pulmonary hemorrhage

DURATION

at onceDue to punctured lung from fractured ribs.Due to Automobile accident

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of Oct 13-46Where did injury occur? Near Vale Summitt Allegany Md.
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) Highway nearMeans of injury Automobile skidded skit pole Injured at work? yes23. SIGNATURE H.V. Deming M.D. H.V. Deming MD
M. D. or otherAddress Cumbrland Md Date signed Oct 13/46Deputy Medical Examiner - Allegany Co

RECEIVED

OCT 22 1946

BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (123)

09609

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County... ALLEGANY
City or town... CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution? 2 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... MARYLAND County... ALLEGANY

City or town... LONACONNING
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (a) FULL NAME

LEONARD DYE, JR.

3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

MALE

WHITE

SINGLE

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) SEPT. 24, 1946

6. (c) If alive, give age..... years

8. AGE: Years Months Days If less than one day
28 hrs. min.9. Birthplace... MARYLAND
(Town, county, and state)

10. Usual occupation... INFANT

11. Industry or business

12. Name... LEONARD DYE, SR.

13. Birthplace... MARYLAND

14. Maiden name... HELEN SMITH

15. Birthplace... MARYLAND

16. Informant... MEMORIAL HOSPITAL

Address... CUMBERLAND, MD.

17. Burial Date thereof Oct. 22, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... Allegany Cem.

Location... Kothburg, Md.

18. Funeral director... M. Eichhorn

Address... Lonacooning, Md.

19. Oct. 22, 1946 J. R. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... OCT. 22, 1946, 3:15 AM

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from Oct 20 to Oct 22 1946

and that I last saw him alive on Oct 22 1946

Immediate cause of death... Peritonitis

Due to... Peritonitis descending

Due to... Small gangrenous area. Impossible to find cause. Duration: 5 days.

Other conditions... C. & R.

DURATION

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE..... M. D. or other

Address..... Date signed... 10/23/46

RECEIVED
OCT 30 1946
BUREAU V. A.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (160-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 09610 4

1. PLACE OF DEATH:

County Allegheny
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 25 minutes
 Hospital, institution, or street address where death occurred:
Allegheny Hospital
 How long in hospital or institution? 20 min. nuxes

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)
 State Maryland County Allegheny
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 541 Fairview Ave
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex Male 5. Color or race W 6. (a) Single, married, widowed, or divorced
7 1/2 mos. newborn.

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) 25 October 1946 8. (c) If alive, give age _____ years

8. AGE: Years _____ Months _____ Days _____ If less than one day
H.B. _____ hrs. 25 min.

9. Birthplace Cumberland, Md
 (Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden name Agnes Irene Ely15. Birthplace Marysavage, Md16. Informant Mrs. Irene ElyAddress 541 Fairview Ave

17. Burial Date thereof Oct 26 1946
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory St Peter & PaulLocation Cumberland, Md18. Funeral director Louis Steier Sr.Address Cumberland, Md19. Oct 26 1946 J. P. Brunkie, M.D.

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 25 1946 at 2:35 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2:10 PM Oct 25 1946 to 2:35 PM Oct 25 1946
 and that I last saw him alive on Oct 25 1946

Immediate cause of death Malnutrition
and 7 1/2 months gestation
 Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE F. D. G. Murray, M.D.Address Cumberland, Md Date signed Oct 26

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Received

RECEIVED
OCT 30 1946
BUREAU V. A.

MARYLAND STATE DEPARTMENT OF HEALTH

DR. HODGES

2411 N. Charles St., Baltimore 16070

CERTIFICATE OF DEATH

Reg. Dist. No. 096114

1. PLACE OF DEATH:

County ALLEGANY
City or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death?
Hospital, institution, or street address where death occurred:MEMORIAL HOSPITAL

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State PENNA. County Bedford
City or town WELLERSBURG
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Jo Ann
BABY GIRL EMERICK

3. (b) Social Security Number

None

4. Sex

FEMALE

5. Color or race

WHITE

6.(a) Single, married, widowed, or divorced

SINGLE

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) OCTOBER 15, 1946 10;58 P.M.
6.(c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

hrs. 47 min.CUMBERLAND, MD.9. Birthplace MEMORIAL HOSPITAL CITY
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
MOTHER12. Name JAMES EMERICK13. Birthplace PENNA.14. Maiden name ALMA DEREMER15. Birthplace PENNA16. Informant Memorial Hosp.
Address Cumberland, Md.17. Burial Date thereof Oct. 17, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Coups GlenLocation Coups Glen, Somerset Co., Penna.18. Funeral director Harvey H. Zeigler
Address Syndman, Penna.19. Oct. 17, 1946 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

OCTOBER 15, 1946 11:45 P.M.20. DATE OF DEATH 1946 at _____ M21. I CERTIFY that death occurred on the date above stated, that I attended deceased from Oct. 13 1946 and that I last saw him alive on Oct. 15 1946

Immediate cause of death

Heart Failure

DURATION

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____

Injured at work _____

23. SIGNATURE

W. P. Hodges, M.D.
Address Cumberland, Md. Date signed 10/17/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

OCT 22 1946

BUREAU V.B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (119a)

CERTIFICATE OF DEATH

096124
Reg. Dist. No.

1. PLACE OF DEATH:

County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 DAYS
Hospital, institution, or street address where death occurred:MEMORIAL HOSPITAL
How long in hospital or institution? 2 DAYS2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)State MARYLAND County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
Street No. 552 N. MECHANIC ST.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

ROBERT FIKE

3. (b) Social Security Number

None4. Sex MALE 5. Color or race WHITE 6.(a) Single, married, widowed, or divorced SINGLE

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) August 30, 1946 6.(c) If alive, give age _____ years8. AGE: Years 1 Months 24 Days _____ If less than one day _____ hrs. _____ min.9. Birthplace MARYLAND, Cumberland, Alleg. Co.
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name _____
13. Birthplace _____14. Maiden name LUCILLE FIKE
15. Birthplace MARYLAND, Friendsville16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MD.17. Burial Date thereof Oct. 26, 1946
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Swage Addition
Friendsville, Md.
Location P.W. Swage18. Funeral director W.W. Swage
Address Friendsville, Md.19. Oct. 26, 1946 Joe P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH OCT. 24, 1946 at 9:30 PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from OCT. 22, 1946 to OCT. 24, 1946
and that I last saw him alive on OCT. 24, 1946

Immediate cause of death

DURATION

Chronic Nutritional Upset
Due to Enterocolitis, Chronic
Duration: 3 years, 2 weeks, 5 days6 wks.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Manner of injury _____ Injured at work? _____

23. SIGNATURE Arthur F. Jones M.D.
M. D. or otherAddress 110 S. Centre St. Date signed 10-25-46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 30 1946
BUREAU V. E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 97

CERTIFICATE OF DEATH

09613

Reg. Dist. No. 4

1. PLACE OF DEATH:

County..... ALLEGANY
 City or town..... CUMBERLAND, MD.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 8 DAYS
 Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
 How long in hospital or institution?..... 8 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... W. VA. County..... MINERAL
 City or town..... BURLINGTON
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... Rural
 (If rural, give LOCATION)
 2.(a) If veteran, name war..... ☒

3. (a) FULL NAME

MRS MATHILDA FLORENTINE

3. (b) Social Security Number

None

4. Sex..... FEMALE 5. Color or race..... WHITE 6. (a) Single, married, widowed, or divorced..... Widow

6. (b) Name of husband or wife..... John Florentine

7. Birth date of deceased (mo., day, yr.)..... June 14, 1867 6. (c) If alive, give age..... years

8. AGE: Years..... 79 Months..... 4 Days..... 11 If less than one day..... hrs. min.

9. Birthplace..... Alexandria, Italy
(Town, County, and State)10. Usual occupation..... HOUSEWIFE11. Industry or business..... II12. Name..... John Bouche13. Birthplace..... Alexandria, Italy14. Maiden name..... Marie Coupe15. Birthplace..... Meland, Italy16. Informant..... MEMORIAL HOSPITALAddress..... CUMBERLAND, MD.

17. Burial..... Date thereof..... 10/28/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Kelbaugh CemeteryLocation..... Elk Garden, W. Va.18. Funeral director..... William H. KightAddress..... Cumberland, Md.

19. Oct 26 19 46 Joe P. Franklin, M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... OCTOBER 25 19 46 at 2:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

10.17.1946 to 10.25.1946
 and that I last saw him alive on 10.24.1946

Immediate cause of death..... Generalizedarteriosclerosis.Infarct ofliver.

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations..... NoneDate of op. NoneAutopsy results..... None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

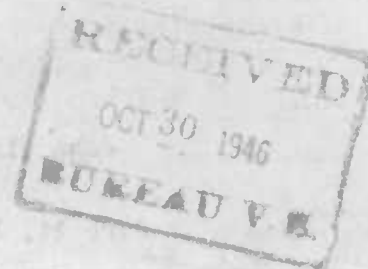
Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... W.F. WilliamsAddress..... Cumberland Date signed 10.25.46



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore



09614

40

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County... Allegany
 City or town... Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?... 36 years
 Hospital, institution, or street address where death occurred:
702 Montgomery Ave
 How long in hospital or institution?...

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... md County... Allegany
 City or town... Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No... 702 Montgomery Ave
 (If rural, give LOCATION)
 2.(a) If veteran, name war...

3. (a) FULL NAME

Emmanuel Henry Ford

3. (b) Social Security Number

None

4. Sex... Male 5. Color or race... White 6.(a) Single, married, widowed, or divorced... Married
 6.(b) Name of husband or wife... Elizabeth B. Kehoe 6.(c) If alive, give age... 76 years
 7. Birth date of deceased (mo., day, yr.)... Feb 12, 1874

8. AGE: Years... 72 Months... 8 Days... 19 hrs... min...

9. Birthplace... Johnstown, Cambria Co., Pa
 (Town, county, and state)

10. Usual occupation... Retired

11. Industry or business... Steel Inspector

12. Name... John Ford

13. Birthplace... Cambria Co. Pa.

14. Maiden name... Suzanne Snyder

15. Birthplace... Blair Co. Pa.

16. Informant... Roderick Ford

Address... Box 60 Rt 2 Hollidaysburg Pa

17. Burial (Burial, cremation, or removal. Which?)... Burial Date thereof... Nov 2, 1946
 (month) (day) (year)

Cemetery or crematory... Benschoff Hill Cemetery

Location... Johnstown Pa.

18. Funeral director... John J. Hofer

Address... Cumberland, Md.

19. Nov 2 1946 J.P. Fawcett M.D. Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH... Oct 31 1946, at 11:55 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 15 1946 to Oct 31 1946
 and that I last saw him alive on Oct 31 1946

Immediate cause of death... Chronic Myocarditis

Due to... Atherosclerosis

Due to...

Other conditions...

(Include pregnancy within 3 months of death)

Major findings of operations...

Date of op...

Autopsy results... Endemic of Card Vase Disease

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... R. Williams, M.D. M. D. or other

Address... Cumberland Md. Date signed... 11/1/46



1-35-

DR. GROVE

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (125)

09615

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANYCity or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITALHow long in hospital or institution? ONE DAY

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County GARRETTCity or town OAKLAND
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION) ✓

2.(a) If veteran, name war _____

3. (a) FULL NAME

JUDSON WILKINSON FOSTER JR.

3. (b) Social Security Number

213-18-2665

4. Sex

MALE

5. Color or race

WHITE

6.(a) Single, married, widowed, or divorced

MARRIED

6.(b) Name of husband or wife

Elizabeth Ashby

7. Birth date of deceased (mo., day, yr.)

December 10, 19216.(c) If alive, give age 19 years

8. AGE:

Years

Months

Days

If less than one day

241011

hrs.

min.

9. Birthplace

MARYLAND, Garrett County
(Town, county, and state)

10. Usual occupation

TIMBER CUTTER

11. Industry or business

FATHER

12. Name

JUDSON FOSTER SR.

13. Birthplace

MARYLAND, Garrett County

14. Maiden name

SABINA JORDAN

15. Birthplace

MARYLAND, Garrett County

16. Informant

MEMORIAL HOSPITAL

Address

CUMBERLAND, MARYLAND

17.

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Oakland Cem

Location

Oakland, Md.

18. Funeral director

Emory D. Bolden

Address

Oakland, Md.

19.

(Date rec'd by registrar)

Oct. 23, 1946. J. P. Franklin, Md.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH OCT. 21 19 46, at 4:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct. 21 19 46, to Oct 21 19 46
and that I last saw him alive on Oct 21 19 46

Immediate cause of death

Lacerated injury to scalp, skull & brain

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 10-21-46Where did injury occur? Garrett Md.
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) Saw millMeans of injury Cut by motor saw Injured at work? yes

23. SIGNATURE

J. B. Some Md.

M. D. or other

Address Medical Bldg Date signed 10-22-46

MARGIN RESERVED FOR BINDING

VS A15

9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 30 1946
BUREAU T. S.

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?
 Hospital, institution, or street address where death occurred:

Allegany Hospital, Cumberland, Maryland

How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 214 Poca Street
 (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

MRS. JULIA E. FRAME

3.(b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Charles R. Frame

7. Birth date of deceased (mo., day, yr.) February 18, 1895 8.(c) If alive, give age 46 years

8. AGE: Years 51 Months 7 Days 14 If less than one day
hrs.min.

9. Birthplace Maryland
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Andrew Mooney
 13. Birthplace Ireland

14. Maiden name Johanna Dignan
 15. Birthplace Ireland

16. Informant Allegany Hospital
 Address 215 Decatur St., Cumberland, Md.

17. Burial Date thereof Oct. 7, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory S.S. Peter & Paul
Cumberland, Md.

18. Funeral director Charles L. George
 Address Cumberland, Md.

19. Oct. 5, 1946 J. B. Franklin
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH October 2, 1946 at 2 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 6, 1946 to October 2, 1946
 and that I last saw her alive on October 2, 1946

Immediate cause of death pulmonary embolism DURATION 14 days

Due to thrombotic embolism
in the pulmonary artery

Due to
 Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations
 Date of op.

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Elizabeth George, M.D.
Comp. Med. M. D. or other

Address Comp. Med. Date signed 10/2/46

CERTIFICATE OF DEATH

LOCAL HEALTH OFFICE OF

PLACE OF BIRTH

RECEIVED

OCT 8 1946

BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

CERTIFICATE OF DEATH

Reg. Dist. No. 8

1. PLACE OF DEATH:

County Allegany
City or town Lozacoming
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 354 days
Hospital, institution, or street address where death occurred:
Douglas Avenue
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Lozacoming
(If outside city or town limits, write RURAL and give nearest town)
Street No. Douglas Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Elizabeth Izett Francis

3. (b) Social Security Number

4. Sex Female 5. Color of race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife James Francis

7. Birth date of deceased (mo., day, yr.) Mar 26, 1888 6. (c) If alive, give age ✓ years

8. AGE: Years 58 Months 6 Days 20 If less than one day

9. Birthplace Midlothian, Allegany Co., Md.
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business own home

12. Name Robert Izett

13. Birthplace Scotland

14. Maiden name Jean Peel

15. Birthplace Scotland

16. Informant Mr. James Francis

Address Washington D.C.

17. Burial (Burial, cremation, or removal, Which) Burial Date thereof Oct 19 1946
(month) (day) (year)

Cemetery or crematory Oak Hill Cemetery

Location Lozacoming, Md.

18. Funeral director Mr. Eickhorn

Address Lozacoming, Md.

19. Oct 19 19 46 Jannette M. Bal Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 16th 19 46, at 8 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Wid not attend 19 to 19

and that I last saw him alive on 19

Immediate cause of death Coronary occlusion

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Henry M. Hadleyson M.D.

Address Lozacoming, Md. Date signed Oct. 18 46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE OF DEATH

RECEIVED
OCT 22 1945
REGISTER

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 170-29

CERTIFICATE OF DEATH

Reg. Dist. No.

09614

1. PLACE OF DEATH:

County Allegheny
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 years
 Hospital, institution, or street address where death occurred:
Allegheny Hospital
 How long in hospital or institution? 3 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Pa. County Allegheny
 City or town Near Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Bowman's Addition, Route 3
 (If rural, give LOCATION)
 2. (a) If veteran, name war World War I

3. (a) FULL NAME

Bruce Christian Fulks

3. (b) Social Security Number

225-14-1087

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Ada Smith
 7. Birth date of deceased (mo., day, yr.) March 13, 1895
 6. (c) If alive, give age 40 years

8. AGE: Years 51 Months 7 Days 1 If less than one day
 hrs. min.

9. Birthplace Fulks Run, Rockingham Co. Va.
 (Town, county, and state)

10. Usual occupation Machinist Helper

11. Industry or business B & O Railroad

12. Name Timothy Fulks

13. Birthplace Fulks Run, Va.

14. Maiden name Fannie Shoemaker

15. Birthplace Fulks Run, Va.

16. Informant Phillip Fulks

Address Fulks Run, Va.

17. Burial Date thereof Oct 17, 1946
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Oak Grove Cemetery

Location Near Fulks Run, Va.

18. Funeral director John J. Huber

Address Cumberland, Md.

19. Oct 17, 46 J. P. Traubler, M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

3-21

20. DATE OF DEATH Oct 14, 1946 at 3:21 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
 19... to 19...
 and that I last saw him alive on im Dead Oct. 14 19 46

Immediate cause of death Intercranial hemorrhage DURATION 27 hrs.

Due to a fracture of the skull

Due to automobile accident

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of Oct 12-46

Where did injury occur? Highway 61, Cumberland Allegheny Md.

Injured at home, farm, industry, public place (where?) Pea Vine Run

Means of injury Automobile Accident Injured at work? yes

Fire Truck Skidded and turned over.

23. SIGNATURE J. P. Traubler, M.D. M. D. or other Allegany

Address Cumberland Md Date signed Oct 14/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

OCT 22 1946

BUREAU V 8

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 920

CERTIFICATE OF DEATH

Reg. Dist. No. 09619 40

DR. HAWKINS
DR. W.F. WILLIAMS

1. PLACE OF DEATH:

County..... ALLEGANY
City or town..... CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution? 6 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... WEST VIRGINIA County..... MINERAL

City or town..... KEYSER
(If outside city or town limits, write RURAL and give nearest town)

Street No. RT. 3

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

MRS. ELLA GLASS

3. (b) Social Security Number

None

4. Sex

FEMALE

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

MARRIED

6. (b) Name of husband or wife..... ARTHUR T. GLASS

6. (c) If alive, give age..... 58 years

7. Birth date of deceased (mo., day, yr.) NOV. 1, 1890

8. AGE:

Years

Months

Days

If less than one day

55 11 25 hrs. min.

9. Birthplace

MARYLAND

(Town, county, and state)

10. Usual occupation..... HOUSEWIFE

11. Industry or business

FATHER
MOTHER

12. Name..... VINCENT WARNICK

13. Birthplace..... MARYLAND

14. Maiden name..... SARAH YOST

15. Birthplace..... MARYLAND

16. Informant

Address

17.

(Burial, cremation, or removal, Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19

46

Jo. I. Franklin, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH OCT. 26 1946 at 5:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
October 20, 1946, to Oct. 26, 1946

and that I last saw him or her on October 25, 1946

Immediate cause of death Rheumatic
Endocarditis

DURATION

Other conditions Small
(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address..... Date signed 10/26/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
NOV 6 1946
BUREAU V.M.

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

09620 40
Reg. Dist. No.

1. PLACE OF DEATH:

County Allegheny
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 76-5-16
 Hospital, institution, or street address where death occurred:
167 N. Centre St.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Allegheny
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 167 N. Centre St.
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

Jacob Gottlieb

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Sarah White
 6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) May 14 1870

8. AGE: Years 76 Months 5 Days 16 If less than one day
 hrs. min.

9. Birthplace Cumberland Ind.
 (Town, county, and state)

10. Usual occupation Printer

11. Industry or business Retired

12. Name Jacob Gottlieb

13. Birthplace Germany

14. Maiden name Fannie Gross

15. Birthplace Germany

16. Informant Mrs. Sarah Gottlieb

Address Cumberland Ind.

17. Burial Date thereof Nov 1 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory East Gate Cem.

Location Cumberland

18. Funeral director Louis Stein Inc.

Address Cumberland

19. Nov 1 46 J. P. Frankish M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 30 1946 at 5:10 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
October 20 1946 to Oct 30 1946
 and that I last saw him alive on Oct 29 1946

Immediate cause of death Pulmonary Embolism
18 hours

Due to Hypertension C.V. Disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE B. M. Schneider M.D.
 M. D. or other

Address 41 Green St. Date signed Oct 30 1946

1-31-
RECEIVED
NOV 6 1946
RECEIVED

Mr Schindler

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH:

County ALLEGANY
City or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 HOURS
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 15 HOURS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State MD. County ALLEGANY
City or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 427 LAING AVE.
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME

MRS JANE ANN GREEN

3. (b) Social Security Number

None

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, married, widowed, or divorced MARRIED

6. (b) Name of husband or wife JOHN M. GREEN

6. (c) If alive, give age 76 years

7. Birth date of deceased (mo., day, yr.) SEPT 24, 1883

8. AGE: Years 63 Months 1 Days 4 If less than one day hrs. min.

9. Birthplace ALLEGANY, CUMBERLAND, MARYLAND
(Town, county, and state)

10. Usual occupation HOUSEWIFE

11. Industry or business

12. Name THOMAS R. Russell

13. Birthplace Glasgow, Scotland

14. Maiden name Margaret Melbourne

15. Birthplace Northumberland, England

16. Informant MEMORIAL HOSPITAL

Address CUMBERLAND, MD.

17. Burial Date thereof Oct. 30, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Marys Cemetery

Location Cumberland, Maryland

18. Funeral director William H. Kight

Address Cumberland, Maryland

19. Oct. 29, 1946 Joseph P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH OCTOBER 28, 1946 4:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 20 to Oct. 28 and that I last saw him alive on Oct. 27

Immediate cause of death Cerebral hemorrhage

Due to Hypertension, U.V.

Due to Stroke

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE B. M. Franklin 41 Greene St. Oct. 29, 1946
M. D. or other Registrar Date signed

RECEIVED
NOV 6 1945
BUREAU V.R.

2-35-

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 73-0

CERTIFICATE OF DEATH

Reg. Dist. No. 096224

1. PLACE OF DEATH:

County Allegheny
City or town Chamberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 day
Hospital, institution, or street address where death occurred Memorial Hospital
How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Penna County Bedford
City or town Hyndman
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2. (a) If veteran, name war _____

3. (a) FULL NAME

George W. Grose

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Anna Conner Grose
8. AGE: Years 81 Months 10 Days 20 If less than one day _____ hrs. _____ min.

7. Birth date of deceased (mo., day, yr.) November 27, 1864
5. (c) If alive, give age 81 years

9. Birthplace Huntingdon, W. Va.
(City, town, county, and state)

10. Usual occupation Retired monument man

11. Industry or business _____

12. Name George W. Grose

13. Birthplace W. Va

14. Maiden name Marta Judy

15. Birthplace md

16. Informant Mrs. Anna M. Grose

Address Hyndman, Pa.

17. Burial, cremation, or removal (Which?) Burial Date thereof Oct 20 1946
(month) (day) (year)

Cemetery or crematory Hyndman

Location Hyndman, Pa.

18. Funeral director Harvey T. Leigler

Address Hyndman, Pa.

19. (Date rec'd by registrar) Oct 19 1946 J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 17 19 46 at 7:08 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 19 46 to Oct. 17 19 46
and that I last saw him alive on Oct. 17 19 46

Immediate cause of death _____

chronic myo cardosis

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE John A. Jager M. D. _____

Address Hyndman, Pa. Date signed 10.17.46

MARGIN RESERVED FOR BINDING

VS A15 9.45.15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

OCT 22 1946

BUREAU V &

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 95-6

CERTIFICATE OF DEATH

Reg. Dist. No. 09623 4

1. PLACE OF DEATH:

County Allegheny
 City or town Cromwell
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 days
 Hospital, institution, or street address where death occurred:
Allegheny Hospital
 How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Allegheny
 City or town Cresaptown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Cunningham Apts.
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Stella Isabelle Phle

3. (b) Social Security Number

NONE

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Mr. George Phle
 6.(c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.) July 28 1907
 8. AGE: Years 39 Months 2 Days 15 If less than one day..... hrs. min.

9. Birthplace Allegheny, Maryland
 (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business.....

12. Name Edward J. Lease
 13. Birthplace Ind.
 14. Maiden name Arzella Lease
 15. Birthplace Ind.

16. Informant Mr. Geo. Phle
 Address Cresaptown Ind.
 17. Burial Date thereof Oct 16 46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Lease Cem.
 Location Triple Lakes Ind.

18. Funeral director Louis Stein Inc.
 Address Cromwell

19. Oct. 16 19 46 J. P. Franklin, M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 13 19 46 at 12:15 P.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 3 19 46 to Oct 13 19 46
 and that I last saw him alive on Oct 12 19 46

Immediate cause of death Coronary heart failure
 Due to rheumatic heart disease

Due to.....
 Other conditions.....
 (Include pregnancy within 8 months of death)

Major findings of operations..... Date of op.....
 Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?).....
 Means of injury..... Injured at work?

23. SIGNATURE L. Phle M.D.
 Address 59 Green St. Date signed 10-14-46
 M. D. or other

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2. 11. 2

RECEIVED

OCT 22 1946

BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 939

09624

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County... ALLEGANYCity or town... CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 80 years

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITALHow long in hospital or institution? 6 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... MARYLAND County... ALLEGANYCity or town... CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)Street No. 10 S. ALLEGANY ST.
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

MISS CORA JONES

3. (b) Social Security Number

None4. Sex FEMALE 5. Color of race WHITE 6.(d) Single, married, widowed, or divorced SINGLE

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) August 4 18668. AGE: Years 80 Months 2 Days 13 If less than one day hrs. min.9. Birthplace MARYLAND Cumberland, Allegay Co.
(Town, county, and state)10. Usual occupation... HOUSE WORK

11. Industry or business

12. Name... JOHN WM. JONES13. Birthplace MARYLAND Cumberland14. Maiden name... JENNIE KEGG15. Birthplace MARYLAND16. Informant... Albert JonesAddress 121 N. Broad St, Philadelphia 7, Pa17. Burial Date thereof 10/19/46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory... Rose Hill CemeteryLocation... Cumberland, Md.18. Funeral director... William H. KightAddress Cumberland, Md.19. Oct. 18 19 46 Joseph C. Zank
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... OCTOBER 17, 1946 19 46 12:25 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 8 19 46 to October 17 19 46
and that I last saw him alive on October 16 19 46Immediate cause of death... chronic myocarditisDue to hypertension

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations..... Date of op.

Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of
Where did injury occur? (City or town) (County) (State)Injured at home, farm, industry, public place (where?)
Means of injury injured at work?23. SIGNATURE John W. Jones M.D.
M. D. or otherAddress Cumberland, Md. Date signed 10/17/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

OCT 22 1946

BUREAU

Within 10 days of death, evidence for the change of residence is shown on
 FILM No. I 0 8 NOV. 12 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 09625

1. PLACE OF DEATH:

County ALLEGANYCity or town GUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State West Virginia County Mineral
MARYLAND ALLEGANYCity or town GUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)Street No. E. ARMSTRONG ST., EXT. KEYSER, W. VA.
E. Armstrong St. Ext.
(If Rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

MRS. OMA JORDAN

3. (b) Social Security Number

None

4. Sex

FEMALE

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

DIVORCED6. (b) Name of husband or wife LUTHER JORDON

7. Birth date of deceased (mo., day, yr.)

APRIL 4, 18746. (c) If alive, give age 75 years

8. AGE:

Years

Months

Days

If less than one day

7268

hrs.

min.

9. Birthplace

WEST VIRGINIA, Grant County

(Town, County, and state)

10. Usual occupation

HOUSE WORK

11. Industry or business

FATHER

12. Name WILLIAM SHROUT13. Birthplace WEST VIRGINIA

MOTHER

14. Maiden name ELIZABETH LOY15. Birthplace WEST VIRGINIA

16. Informant

Memorial Hospital

Address

Gumberland, Md.

17.

(Burial, cremation, or removal) Which?

Date thereof

Oct. 15, 1946
(month) (day) (year)

Cemetery or crematory

Laymansville Ceme.

Location

Laymansville, W. Va.

18. Funeral director

W. H. Rogers Funeral Hse.

Address

Keyser, W. Va.

19.

(Date rec'd by registrar)

Oct. 12, 46J. P. Faulkner, M.D.

Registrar

MEDICAL CERTIFICATION

5;10 A.M.

20. DATE OF DEATH OCTOBER 12, 1946

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept. 30, 1946 to Oct. 12, 1946and that I last saw him alive on Oct. 12, 1946

Immediate cause of death

post-operative shockDue to perforated ulcerDue to deliriumDue to post-operative hemorrhageOther conditions massive adhesions

(Include pregnancy within 3 months of death)

Major findings of operations

as aboveDate of op. 10/9/46

Autopsy results

as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

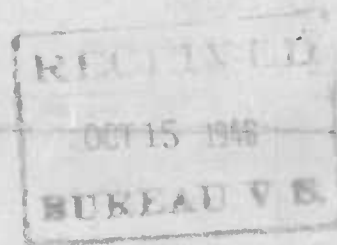
Means of injury Injured at work?

23. SIGNATURE

J. P. Faulkner

M. D. or other

Address Gumberland, Md. Date signed 10/12/46



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

CERTIFICATE OF DEATH

Reg. Dist. No. 096264

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution? 1 DAY

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

Street No. 882 EEPHART DRIVE
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

MRS. ESTELLE KUNES

3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

FEMALE

WHITE

MARRIED

6. (b) Name of husband or wife FLOYD KUNES

7. Birth date of deceased (mo., day, yr.) MAR. 18, 1884
6. (c) If alive, give age. 68 years

8. AGE: Years Months Days It less than one day
62 6 22 hrs. min.

9. Birthplace PENNA. Bedford County
(Town, county, and state)

10. Usual occupation HOUSEWIFE

11. Industry or business

12. Name AUGUSTUS THOMAS

13. Birthplace PENNA. Bedford County

14. Maiden name MARILLA NORTON

15. Birthplace PENNA. Bedford County

16. Informant MEMORIAL HOSPITAL

Address CUMBERLAND, MD.

17. Burial Date thereof Oct 12, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Hyndman Cemetery

Location Hyndman Pa.

18. Funeral director John J. Haler

Address Cumberland Md.

19. Oct. 12, 1946 J. P. Franklin, M.D. Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH OCT. 10, 1946 10:15 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from OCT. 9, 1946, to OCT. 10, 1946

and that I last saw her alive on OCT. 10, 1946

Immediate cause of death Left Cerebral Hemorrhage Right Hemiplegia

DURATION 10-9-46 10-7-46

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Clay J. Sumner M. D. or other

Address Cumberland Date signed 10-10-46

RECEIVED

OCT 15 1946

BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH:

County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? FIVE DAYS

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITALHow long in hospital or institution? FIVE DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County Garrett
City or town Mt. Lake Park
(If outside city or town limits, write RURAL and give nearest town)Street No. MT. LAKE PARK, MARYLAND
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

HUBBERT V. LEIGHTON4. Sex MALE 5. Color or race WHITE 6. (d) Single, married, widowed, or divorced MARRIED6. (b) Name of husband or wife MARY MAUDE LEIGHTON7. Birth date of deceased (mo., day, yr.) SEPT. 22, 18708. AGE: Years 76 Months 0 Days 0 If less than one day
hrs. 0 min. 09. Birthplace WEST VIRGINIA
(Town, county, and state)10. Usual occupation LUMBER BUSINESS11. Industry or business Own Business12. Name ISAAC LEIGHTON13. Birthplace ENGLAND14. Maiden name ELIZABETH FRITH15. Birthplace ENGLAND16. Informant MEMORIAL HOSPITALAddress CUMBERLAND, MARYLAND17. Burial Date thereof Oct. 30, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Oakland CemeteryLocation Oakland, Md.18. Funeral director John J. HofferAddress Cumberland, Md.19. Oct. 29, 1946 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH OCTOBER 27, 1946 at 3:15 P21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 27, 1946 to Oct. 27, 1946and that I last saw him alive on Oct. 27, 1946Immediate cause of death Coronary Occlusion

DURATION

Due to Coronary OcclusionDue to Arteriosclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations NoneAutopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. F. Williams M. D. or otherAddress Cumberland Date signed 10/27/46



2-35-

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 096880

1. PLACE OF DEATH:

County Allegany
 City or town Monacaoning
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 45 years
 Hospital, institution, or street address where death occurred:
Rockville St.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Allegany
 City or town Monacaoning
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Rockville St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war 1

3. (a) FULL NAME

George Lintz

3. (b) Social Security Number

1

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Margaret Stewart Lintz

7. Birth date of deceased (mo., day, yr.) June 18, 1872 6. (c) If alive, give age 56 years

8. AGE: Years 74 Months 4 Days 10 If less than one day _____ hrs. _____ min.

9. Birthplace Barton, Allegany Co., Md.
 (Town, county, and state)

10. Usual occupation Coal Miner Retired

11. Industry or business Jenkins Mine

12. Name John V. Lintz

13. Birthplace Germany

14. Maiden name Marguerite Weisner

15. Birthplace Germany

16. Informant Mrs. W. Ellington Corn

Address Barton, Md.

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Oct. 31, 1946
 (month) (day) (year)

Cemetery or crematory Oak Hill Cemetery

Location Monacaoning, Md.

18. Funeral director W. E. Eickhorst

Address Monacaoning, Md.
Oct. 21 19 46 Jannette M. Boal
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 28, 1946 at 11 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 28, 1946 to Oct. 28, 1946

and that I last saw him alive on Oct. 28, 1946

Immediate cause of death Endocarditis

One to _____

One to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide 44 Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work?

23. SIGNATURE Henry W. Hodgson M.D.
 Address Monacaoning, Md. Date signed Oct. 30/46

UNITED STATES DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

IN THE CITY AND COUNTY OF

STATE OF

DEPARTMENT OF HEALTH

1-35

RECORDED
NOV 5 1945

1-

Oct 31 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 92d

CERTIFICATE OF DEATH

09629

Reg. Dist. No. 10

1. PLACE OF DEATH:

County AlleganyCity or town 2nd Savage
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town 2nd Savage
(If outside city or town limits, write RURAL and give nearest town)Street No. 2nd Row
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male White Married

6. (b) Name of husband or wife Bernard F. Logsdon

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematorium

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

Registrar

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH October 11 1946, at 5 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from several years 1946, to Oct 11 1946, and that I last saw him alive on Oct 9 1946.

Immediate cause of death

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed

RECEIVED

OCT 17 1946

BUREAU V B

Within corporate limits

M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09630

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 50 yrs.

Hospital, institution, or street address where death occurred:

417 Magnander St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 417 Magnander St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Gertrude Boor Inacheth

3. (b) Social Security Number

none4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife James E. Inacheth

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) June 30 18798. AGE: Years 67 Months 3 Days 9 If less than one day _____ hrs. _____ min.9. Birthplace Hazen Ind.
(Town, county, and state)10. Usual occupation Housework11. Industry or business at home12. Name John W. Boor13. Birthplace Pa.14. Maiden name Melissa Ash15. Birthplace Ind.16. Informant Inacheth BoorAddress Cumberland17. Burial Date thereof Oct 11 '46
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Rox Hill Cem.Location Cumberland18. Funeral director Louis Stein IncAddress Cumberland19. Oct 11 19 46 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 9 19 46, at 10:30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1st 19 46, to Oct 9 19 46, and that I last saw him alive on Oct 6 19 46Immediate cause of death Chronic myocarditis DURATION 6 mosDue to Arterial hypertension 1 year

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE R. H. Truskis, M.D. M. D. or other _____Cumberland, Md Date signed Oct 10/46

MARGIN RESERVED FOR BINDING

I

VS A15

9-45-151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

OCT 15 1946

BUREAU R S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

09631

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County Allegheny
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 74-8-6

Hospital, institution, or street address where death occurred:

54 Oak St.

How long in hospital or institution?

3. (a) FULL NAME

John Martin

3. (b) Social Security Number

None4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife Kenneth H. Hirsch

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) Feb 2 18728. AGE: Years 74 Months 8 Days 6 If less than one day..... hrs. min.9. Birthplace Cumberland Md
(Town, county, and state)10. Usual occupation Glass blower11. Industry or business Retired 22 yrs12. Name Martin Martin13. Birthplace Germany14. Maiden name Elizabeth15. Birthplace Germany16. Informant Mrs Carl S. BuschelAddress Cumberland17. Burial Date thereof Oct 10 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory German Beneficial ConLocation Cumberland18. Funeral director Louis Stein Inc.Address Cumberland19. Oct. 10 19 46 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County AlleghenyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 54 Oak St.
(If rural, give LOCATION)

2. (a) If veteran, name war.....

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 8 19 46 at 5:30 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 5 19 46 to Oct 8 19 46and that I last saw him alive on Oct 8, 1946Immediate cause of death Chronic Myocarditis

DURATION

Due to Old age.

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury Off Highway Injured at work?23. SIGNATURE W. B. Bldy M. D. or otherAddress 107/46 Date signed.....

RECEIVED

OCT 15 1946

BUREAU OF

VS A15 9-45-15 MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore 68-6
CERTIFICATE OF DEATH

DR. ENFIELD

★ 096324
Reg. Dist. No.

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 years
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 11 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
Street No. 524 N. MECHANIC ST.
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME Mrs
MRS. LAURA MARTIN
3. (b) Social Security Number 215-20-7057

4. Sex FEMALE 5. Color or race WHITE 6.(a) Single, married, widowed, or divorced MARRIED

6.(b) Name of husband or wife DAVID MARTIN
6.(c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) JULY 26, 1909

8. AGE: Years 37 Months 2 Days 8 If less than one day _____ hrs. _____ min.

9. Birthplace PENNSYLVANIA, Dunbar
(Town, county, and state)

10. Usual occupation HOUSEWIFE

11. Industry or business own home

12. Name SEATON CHALMER Chalmer Seaton

13. Birthplace PENNSYLVANIA, Dunbar

14. Maiden name MARY FITZMAURICE Fitzmaurice

15. Birthplace PENNSYLVANIA, Fairchance

16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MD.

17. Burial Date thereof October 7, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Green Ridge Memorial Cemetery

Location Cannellville, Pa.

18. Funeral director John J. Hefner

Address Cumberland, Md.

19. October 6, 1946 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH OCTOBER 4 19 46, at 2:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 23 19 46 to Oct 4 19 46
and that I last saw him alive on Oct 4 19 46

Immediate cause of death _____ DURATION _____

Due to following shot

Due to chest

Other conditions _____

(Include pregnancy within 3 months of death)
Major findings of operation fractured

Autopsy results _____ Date of op. 9/26/46

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE _____

Address _____ Date signed 10/6/46

RECEIVED

OCT 15 1946

BUREAU V S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 8

09633

1. PLACE OF DEATH:

County Allegany
City or town Garacoring
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death.....
Hospital, institution, or street address where death occurred:
East Main
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Garacoring
(If outside city or town limits, write RURAL and give nearest town)
Street No. East Main St.
(If rural, give LOCATION)
2. (a) Is veteran, name war.....

3. (a) FULL NAME

John M. Alpine

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Jessie Helen McElwain
6. (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) Aug. 12, 1870

8. AGE: Years 76 Months 2 Days 12 If less than one day hrs. min.

9. Birthplace Garacoring, Allegany Co., Md.
(Town, county, and state)

10. Usual occupation Clothier & Merchant (Retired)

11. Industry or business Cover Business

12. Name John M. Alpine

13. Birthplace Scotland

14. Maiden name Eliz. Flemming

15. Birthplace Scotland

16. Informant Mrs. Conrad Wilson

Address Garacoring, Md.

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Oct. 26, 1946
(month) (day) (year)

Cemetery or crematory Hill Crest Cemetery

Location Cumberland, Md.

18. Funeral director W. Eichhorn

Address Garacoring, Md.

19. Oct 25 1946 (Date rec'd by registrar) Janneth M. Coal Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 24 19 46, at 12:15 P.M.

I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 23, 1946 to Oct. 24, 1946
and that I last saw him alive on Oct. 24, 1946

Immediate cause of death Coronary occlusion

Due to.....
Other conditions.....
(Include pregnancy within 8 months of death)

Major findings of operations..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Henry M. Hodgson M.D. M. D. or other

Address Garacoring, Md. Date signed Oct. 25 1946

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 170-2

CERTIFICATE OF DEATH

Reg. Dist. No. 09634

1. PLACE OF DEATH:

County AlleganyCity or town Near Old Town Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Pa. County AlleganyCity or town Wilkinsburg
(If outside city or town limits, write RURAL and give nearest town)Street No. 190 Spring Grove Road.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Miles G Mc Kenney

3. (b) Social Security Number

172-12-5804

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Elizabeth Vogtsberger8. (c) If alive, give age 34 years7. Birth date of deceased (mo., day, yr.) May 19, 1909

8. AGE:

Years

37

Months

5

Days

4

If less than one day

hrs. min.

9. Birthplace

Pittsburg, Penna.

(Town, county, and state)

10. Usual occupation

Orchard worker

11. Industry or business

Appalacian Orchards

FATHER

12. Name William G. McKenney

13. Birthplace

Pittsburg, Penna.

MOTHER

14. Maiden name

Helen O'Brien

15. Birthplace

New York City

16. (Informant)

Mrs. P. J. Joyce

Address

6736 Thomas Blvd. Pittsburg, Pa.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Oct. 28, 1946

(month) (day) (year)

Cemetery or crematory

Calvary Cem.

Location

Pittsburg, Penna.

18. Funeral director

H. Wayne George

Address

Cumberland, Md.19. Oct. 28, 1946
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 23 19 46 at 6:30 A.M. about

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 46 to 19 46and that I last saw him Dead Oct. 23 19 46

Immediate cause of death

Pulmonary hemorrhageDURATION
about 40 min.Due to Crushed chest(about 5:50 A.M.)

Due to

Other conditions Other fractures of body

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of Oct. 23/46Where did injury occur? near Paw Paw Hampshire W. Va.
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) HighwayMeans of injury Presume hit by a truck Injured at work? no

23. SIGNATURE

W. V. Downing M.D.

M. D. or other

Address Cumberland, Md. Date signed 10-23-46Deputy Medical Examiner - Allegany Co.

RECEIVED
OCT 29 1946
BUREAU T

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH Dr. P. R. Wilson

2411 N. Charles St., Baltimore (31-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 09635

1. PLACE OF DEATH:

County Allegany
 City or town Westernport
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?
 Hospital, institution, or street address where death occurred:

419 Maryland Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany
 City or town Westernport
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 419 Maryland Ave
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

James Aloysius Niland

3. (b) Social Security Number

217-05-1121

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Married

6. (b) Name of husband or wife Anna Rhea Dixon Niland6. (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) April 15, 1882

8. AGE: Years Months Days If less than one day
64 5 24 hrs. min.

9. Birthplace Piedmont-Mineral-W. Va.
 (Town, county, and state)

10. Usual occupation Digester Cook11. Industry or business Pulp and Paper Mill12. Name Thomas Niland13. Birthplace Ireland14. Maiden name Mary E. Kelly15. Birthplace Piedmont, W. Va.16. Informant Mr. James NilandAddress Westernport, Md.

17. burial Date thereof 12 Oct 1946
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Philos CemeteryLocation Westernport, Md18. Funeral director Ellsworth S. BoalAddress 111 Church St., Westernport, Md.

19. Oct 11 19 46 22 Staginkabor 7MI
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 9, 1946 19 46 at 11 p.m.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept 29 10 19 46 to Oct 9 19 46
 and that I last saw him live on Oct 9 - 46 19 46

Immediate cause of death

Chronic nephritis
Hypertension

DURATION

23x
203m

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE P. E. Berry M.D.

Piedmont W. Va. M. D. or other
 Address Piedmont W. Va. Date signed 10/11/46

RECEIVED
OCT 14 1946
BUREAU V. E.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 113-34

CERTIFICATE OF DEATH

09636
Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Lifetime
 Hospital, institution, or street address where death occurred:
Memorial Hospital
 How long in hospital or institution? 3 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 123 West Second Street
 (If rural, give LOCATION)
 2.(a) if veteran, name war

3. (a) FULL NAME

Mrs. (H.E.) Blanch Northcraft

3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female white married

6. (b) Name of husband or wife H. E. Northcraft

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 30, 1895

8. AGE: 51 Years 14 Months 22 Days If less than one day hrs. min.

9. Birthplace Cumberland, Md.
(Town, county, and state)10. Usual occupation Housewife11. Industry or business Home12. Name Thomas Troxell13. Birthplace Md.14. Maiden name Jermiah Robinette15. Birthplace Md16. Informant H.E. NorthcraftAddress Cumberland, Md17. Burial Date thereof Oct. 25, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Hillcrest Ceme.Location Cumberland, Md18. Funeral director Louis Stein, Inc.Address Cumberland, Md19. Oct. 24, 1946 J. P. Franklin M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 22 19 46, at 5:05 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 to 19 and that I last saw him er Dead Oct. 22 19 46

Immediate cause of death

Poisoning by lysolDURATION
about one hr.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Suicide Date of Oct. 22-46

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE H.V. Deming M.D. H.V. Deming M.D.
M. D. or otherAddress Cumberland, Md Date signed 10-23/46

Deputy Medical Examiner - Allegany Co.

MARGIN RESERVED FOR BINDING

VS A15 9-45-19

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 30 1946
BUREAU V R

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County.....ALLEGANY

City or town.....CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution? 11 DAYS

3. (a) FULL NAME

PAULMAN, GEORGE

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

MALE WHITE WIDOWED

6. (b) Name of husband or wife. PAULMAN, MARY

7. Birth date of deceased (mo., day, yr.) DECEMBER 14, 1879

8. AGE: Years Months Days If less than one day
67 9 29 hrs. min.9. Birthplace. NEW YORK (Elmira)
(Town, county, and state)

10. Usual occupation. PHYSICIAN

11. Industry or business

12. Name. Charles Paulman

13. Birthplace. Germany

14. Maiden name. Julia Russell

15. Birthplace. Elmira, N.Y.

16. Informant. MEMORIAL HOSPITAL
Address CUMBERLAND, MARYLAND17. Burial Date thereof. Oct. 16, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory. St. Lukes Cem.

Location. Cumberland, Md.

18. Funeral director. Charles L. George

Address. Cumberland, Md.

19. Oct. 16, 1946 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State. MARYLAND County. ALLEGANY

City or town. CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)Street No. 207 FULTON STREET
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH. OCTOBER 13 1946 at 3:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 15 Oct. 1946 to 17 Oct. 1946
and that I last saw him alive on 17 Oct. 1946

Immediate cause of death. Coronary Heart Disease 2 mths.

Due to. Hypertensive Heart Disease?

Due to. a

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations.

Date of op.

Autopsy results.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE. W. A. Van Ormer M. D. or other

Address. 114 S. Center St. Date signed. 15 Oct. 46

RECEIVED

OCT 22 1946

BUREAU V 8

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 64

CERTIFICATE OF DEATH

09638 4
Reg. Dist. No.

1. PLACE OF DEATH:

County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 10 yrs

Hospital, institution, or street address where death occurred:

Allegany Hospital
How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 320 Maryland Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Eileen Mae Perkins

3. (b) Social Security Number

None

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female white Single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Nov 15, 19358. AGE: Years Months Days If less than one day
10 10 24 hrs. min.9. Birthplace Cumberland Allegany Co, Md
(Town, county, and state)10. Usual occupation School Child

11. Industry or business

12. Name James Perkins13. Birthplace Lord, Md14. Maiden name Katherine Troutman15. Birthplace Gilpintown, Md.16. Informant Mrs. James PerkinsAddress 320 2nd Ave - Cumberland Md17. Burial Date thereof Oct 11, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Greenmont CemeteryLocation Cumberland Md18. Funeral director John J. HaferAddress Cumberland Md19. Oct 10 19 46 J.P. Faulkner M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 9 19 46 at 6 a M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 7 19 46 to Oct 9 19 46
and that I last saw him alive on Oct 9 19 46Immediate cause of death Status Thymico lymphaticus DURATION 7 days

Due to

Due to

Other conditions Terminal Pneumonia 18 hrs

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Status Thymico lymphaticus

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. W. Kewaskis Jr. M.D. M. D. or otherAddress 220 Baltimore Ave. Date signed 10-9-46

MARGIN RESERVED FOR BINDING

VS A15

9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 15 1946
BUREAU V S

Outside of
City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 87-9

CERTIFICATE OF DEATH

Reg. Dist. No. 4

09639

1. PLACE OF DEATH:

County Allegany
City or town Rural Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 yrs.
Hospital, institution, or street address where death occurred Cash Valley Rd. - R.F. D. #1
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Rural Cumberland - Long
(If outside city or town limits, write RURAL and give nearest town)
Street No. Cash Valley Rd.
(If rural, give LOCATION)
2. (a) If veteran; name war Spanish-American

3. (a) FULL NAME

Lewis William Peterman

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
6. (b) Name of husband or wife Myrtle Valentine
7. Birth date of deceased (mo., day, yr.) Nov. 1, 1874 6. (c) If alive, give age years
8. AGE: Years 71 Months 11 Days 15 It less than one day hrs. min.

9. Birthplace Cumberland Ind.
(Town, county, and state)

10. Usual occupation Operator - power machine

11. Industry or business Retired

12. Name Tollbert E. Peterman

13. Birthplace Ind.

14. Maiden name Mary R. Miller

15. Birthplace Ind.

16. Informant Mrs. Dennis N. Peterman

Address Cash Valley Rd.

17. Burial Date thereof Oct 19 46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Hillcrest Cem.

Location Cumberland

18. Funeral director Louis Stein Inc.

Address Cumberland

19. Oct. 18, 19 46 J. P. Franklin M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 16 19 46 at 3 p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 35 to Oct 16 19 46
and that I last saw him alive on Oct 16 19 46

Immediate cause of death Congestive heart failure

Due to Coronary atherosclerosis & weak
to Paralysis of heart 18 yrs.

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

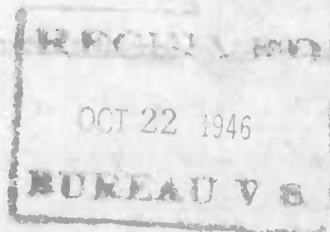
Means of injury Injured at work?

23. SIGNATURE A. Allen E. Murray M.D.
M.D. or other
Address Cumberland Date signed Oct 17 46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



Dr. Murray

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09640

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 76 Years
 Hospital, institution, or street address where death occurred:
117 North Allegany St
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 117 North Allegany St
 (If rural, give LOCATION)
 2. (a) If veteran, name war Civil War

3. (a) FULL NAME

James Reed

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed
 6. (b) Name of husband or wife Elizabeth Reed
 6. (c) If alive, give age years
 7. Birth date of deceased (mo., day, yr.) April 3 1846
 8. AGE: Years 100 Months 6 Days 17 If less than one day hrs. min.

9. Birthplace Beaver, Pa.
 (Town, county, and state)
 10. Usual occupation Boatman
 11. Industry or business C & O Canal
 12. Name Thomas Reed
 13. Birthplace Unknown
 14. Maiden name Isabelle Unknown
 15. Birthplace Ireland

16. Informant Miss Anna Reed
 Address 117 North Allegany St, Cumberland, Md.
 17. Burial Date thereof 10/23/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Rose Hill Mausoleum
Cumberland, Md.
 Location
 18. Funeral director William H. Kight
 Address Cumberland, Md.

19. Oct 23 1946 J. P. Franklin, M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 20 1946 at 5-30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1 1946 to Oct. 20 1946
 and that I last saw him alive on Oct. 17 1946

Immediate cause of death Sudden Cardiac Vasculor
renal disease
 Due to
 Due to
 Other conditions
 (Include pregnancy within 3 months of death)

Major findings of operations none
 Date of op.

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE D. B. Sime M.D.
 Address Medical Bldg Date signed 10-21-46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 30 1946
BUREAU P. I.

45
1981
1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 096440

1. PLACE OF DEATH:

County Allegheny
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 25 yrs
 Hospital, institution, or street address where death occurred:
907 Virginia Ave.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Allegheny
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 907 Virginia Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Wrentha Reynolds

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Victor Reynolds
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) Oct 24, 1893
 8. AGE: Years 53 Months - Days 4 It less than one day _____ hrs. _____ min.

9. Birthplace Penna
 (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business
 12. Name Nathan Hill
 13. Birthplace Penna
 14. Maiden name Ortiz
 15. Birthplace Pa.

16. Informant Mrs Marie A. New
 Address Cumberland
 17. Burial Date thereof Oct 28 46
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory Hillcrest Cem.
 Location Cumberland
 18. Funeral director Louis Stein Inc
 Address Cumberland
 19. Oct 28 46 J. P. Franklin, M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 25 1946 at 3:30 P.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
March 10 1946 to Oct 24 1946
 and that I last saw him alive on Oct 26 1946

Immediate cause of death Central Hemorrhage DURATION 3 hrs
 Due to Arterio Sclerosis +
Hypertension 870
 Due to
 Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations ✓ Date of op. ✓
 Autopsy results ✓
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide ✓ Date of ✓
 Where did injury occur? ✓ (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE J. P. Franklin M. D. or other
 Address 101 S. Centre St Date signed 10/26/46

MARGIN RESERVED FOR BINDING

VS A15

9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (943)

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH: Allegany
 County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....
 Hospital, institution, or street address where death occurred:
163 Maple St
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Allegany
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 163 Maple St
 (If rural give LOCATION)
 2. (a) If veteran, name war.....

3. (a) FULL NAME John Joseph Rodda

3. (b) Social Security Number

none

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married
 6. (b) Name of husband or wife Daisy Rodda
 7. Birth date of deceased (mo., day, yr.) February 29, 1871 6. (c) If alive, give age 58 years
 8. AGE: Years 75 Months 7 Days 5 If less than one day.....hrs.min.

9. Birthplace Frostburg, Allegany, Md
 (Town, county, and state)

10. Usual occupation retired

11. Industry or business merchant

12. Name Mathias H. Rodda

13. Birthplace England

14. Maiden name Ann Hick

15. Birthplace England

16. Informant Mrs. John Rodda

Address Frostburg Md

17. Burial Date thereof Oct. 7, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Allegany Cemetery

Location Frostburg Md.

18. Funeral director J. B. Oberst

Address Frostburg Md

19. 10-7 19 46 Mrs. Nancy H. Roe
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 5 19 46 at 7:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1944 to Oct 3 19 46

and that I last saw him alive on Aug 1 19 46

Immediate cause of death Coronary Arteriosclerosis

DURATION Sudden

Due to Arterio Sclerosis

Due to several years

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE Wm Lane, MD M. D. or other

Address Frostburg Md Date signed 10-7-46

RECEIVED

OCT 9 1946

BUREAU V S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (7)

CERTIFICATE OF DEATH

09643 4
Reg. Dist. No.

1. PLACE OF DEATH:

County..... Allegany
 City or town..... Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 6 Years
 Hospital, institution, or street address where death occurred:
Allegany County Infirmary
 How long in hospital or institution?..... 8 Months 20 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... Maryland County..... Allegany
 City or town..... Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 322 Grand Ave
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Annie Laurie Schell

3. (b) Social Security Number

None

4. Sex..... Female 5. Color or race..... White 6.(a) Single, married, widowed, or divorced..... Single
 6.(b) Name of husband or wife.....
 6.(c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.)..... July 6 1862
 8. AGE: Year..... 84 Months..... 3 Days..... 14 If less than one day..... hrs. min.

9. Birthplace..... Burlington, Mineral Co., West Virginia
(Town, county, and state)10. Usual occupation..... School Teacher11. Industry or business..... Teaching12. Name..... William G. Schell13. Birthplace..... Burlington, W. Va.14. Maiden name..... Mary Jane Bradford15. Birthplace..... Burlington, W. Va.16. Informant..... Mrs. T. E. MorrisonAddress..... 305 Arch St. Cumberland, Md.17. Burial..... Date thereof..... 10/23/46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory..... Burlington CemeteryLocation..... Burlington, W. Va.18. Funeral director..... William H. KightAddress..... Cumberland, Md.19. Oct. 23 46 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH..... October 20 1946 at 9-30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
1-31- 1946 to 10-20-1946
and that I last saw him alive on 10-19-1946

Immediate cause of death.....
Generalized
arteriosclerosis
suppuratives of
eye
 Due to.....
 Due to.....
 Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... NoneDate of op. NoneAutopsy results..... None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... W. F. Williams M. D. or otherAddress..... Cumberland Date signed 10-21-46

51700



DR. WISMAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

09644

40

1. PLACE OF DEATH:

County... ALLEGANY

City or town... CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution? TWENTY DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... MARYLAND County... ALLEGANY

City or town... CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)Street No. 610 GREEN ST.
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

ALVIN SEIF, Sr.

3. (b) Social Security Number

None

4. Sex

MALE

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

MARRIED

6. (b) Name of husband or wife VIOLA SEIF

7. Birth date of deceased (mo., day, yr.)

OCTOBER 4, 1896

6. (c) If alive, give age. 54 years

8. AGE:

56

Years

Months

0

Days

14

If less than one day

hrs.

min.

9. Birthplace

PENNSYLVANIA

(Town, county, and state)

10. Usual occupation

Musical Instructor

11. Industry or business

Self

FATHER

12. Name

EDWARD SEIF

13. Birthplace

York, Pa.

MOTHER

14. Maiden name

ANN ELESSER

15. Birthplace

York, Pa.

16. Informant

MEMORIAL HOSPITAL

Address

CUMBERLAND, MARYLAND

17. Burial

(Burial, cremation, or removal, Which?)

Date thereof

Oct. 28, 1946

(month) (day) (year)

Cemetery or crematory

Rose Hill Mausoleum

Location

Cumberland, Md.

19. Funeral director

Charles L. George

Address

Cumberland, Md.

19.

(Date rec'd by registrar)

19. 46

J. P. Franklin, M.D.

Registrar

MEDICAL CERTIFICATION

P

20. DATE OF DEATH... OCTOBER 25... 19. 46... at 9:30... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

5 Oct

19. 46, to

25 Oct

19. 46

and that I last saw him alive on October 25... 19. 46

Immediate cause of death Multiple cerebral

Embolicism from mural

Thrombosis of Left Ventricle

Myocardial Infarction

Apical type

Due to Atherosclerosis, hyper-

tension and coronary

Sclerosis

Other conditions

DURATION

2 days

13 days

?

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

A. B. O. Wisman MD

M. D. or other

Address

Cresaptown, Md.

Date signed

27 Oct 46

RECEIVED
NOV 6 1946
BUREAU OF

2-35-

Trevaskis

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore
CERTIFICATE OF DEATH

09645

Reg. Dist. No. 40

1. PLACE OF DEATH:
County Allegheny
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 yrs.
Hospital, institution, or street address where death occurred:
339 City View Terrace
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MD County Allegheny
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 339 City View Terrace
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME George Shipper

3. (b) Social Security Number None

4. Sex Male
5. Color or race white
6. (a) Single, married, widowed, or divorced Divorced
6. (b) Name of husband or wife Caroline Richer

6. (c) If alive, give age 60 years
7. Birth date of deceased (mo., day, yr.) June 8, 1873

8. AGE: Years 73 Months 4 Days 21 hrs. min.

9. Birthplace Jones Springs, Berkeley Co., W. Va.
(Town, county, and state)

10. Usual occupation Retired Conductor

11. Industry or business B & O. Railroad

12. Name Wm. Shipper

13. Birthplace Germany

14. Maiden name Rebecca Richards

15. Birthplace Unknown

16. Informant Wm. T. Shipper
Address 339 City View Terrace, Cumberland

17. Burial Burial Date thereof October 31, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Hedgesville Cemetery
Location Hedgesville, W. Va.

18. Funeral director John J. Haley
Address Cumberland, Md.

19. Oct. 31, 1946 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 29 19 46 at 7:20 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1 19 46 to Oct 29 19 46
and that I last saw him alive on Oct 11 19 46

Immediate cause of death Chronic Myocarditis DURATION 1 year

Due to

Due to

Other conditions Arteriosclerosis 18 Mos.
(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. M. Trevaskis, Sr., M.D.
Address Cumberland, Md. Date signed Oct 29-46

MARGIN RESERVED FOR BINDING

9-45-15

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
NOV 6 1946
BUREAU V.B.

2-35-

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 80-8

CERTIFICATE OF DEATH

Reg. Dist. No. 4

09646

1. PLACE OF DEATH:

County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Memorial HospitalHow long in hospital or institution? 3 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 428 Green St.
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Effie Dora Rice Shives

3. (b) Social Security Number

Rose

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Harvey R. Shives

7. Birth date of

deceased (mo., day, yr.)

Nov. 1, 1876

6. (c) If alive, give age. years

8. AGE:

Years

Months

Days

If less than one day

691111

hrs.

min.

9. Birthplace Robertsville, Wash. Co., Md.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER

12. Name

Charles Rice

13. Birthplace

New York

MOTHER

14. Maiden name

Susanna Cyler

15. Birthplace

Wash. Co., Md.

16. Informant

Mrs. Mabel Foley

Address

428 Green St., Cumberland.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Oct. 15, 1946
(month) (day) (year)

Cemetery or crematory

Shives Cemetery

Location

Timber Ridge (near Hancock, Md.)

18. Funeral director

Charles R. Bast

Address

Hancock, Md.

19. Oct. 14, 1946

(Date rec'd by registrar)

19. 46

J. P. Franklin, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct 8 12

19

at

19

at

19

at

19

at

19

21. I CERTIFY that death occurred on the date above stated; that it ended at

Sept 25

19

at

19

at

19

at

19

at

19

at

19

at

19

and that I last saw him alive on

Oct 12, 46

19

at

19

at

19

at

19

at

19

at

19

Immediate cause of death

Encephalitis

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

R. J. Williams, M.D.

M. D. or other

Address

Med. Bldg.Date signed 10/12/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

OCT 22 1946

BUREAU V &

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 15706

CERTIFICATE OF DEATH

Reg. Dist. No. 6

09647

1. PLACE OF DEATH:

County AlleganyCity or town Dawson
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County AlleganyCity or town Dawson
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Ella Mae Shreve.

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.) Oct. 19, 1946

8. AGE:

Years

Months

Days

If less than one day

5

..... hrs. min.

9. Birthplace Dawson Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name Arley Shreve.13. Birthplace Ketterman, W.Va.

MOTHER

14. Maiden name Hazel Lewis.15. Birthplace Cumberland, Md.16. Informant Arley Shreve,Address R.F.D. 3 Keyser, W.Va.17. Burial Date thereof Oct. 25, 46.
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Dawson CemeteryLocation Dawson, Md.18. Funeral director None in charge. Ernest KeeneAddress Dawson, Md.19. Oct. 24 1946
(Date rec'd by registrar)Ernest Keene
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 24, 1946. 19..... at 4..... A..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct 19 1946 to 10-24 1946
and that I last saw her alive on Oct 23 1946

Immediate cause of death

Meningitis

DURATION

1-2 daysDue to Infectious Spinal Polio.

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

..... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Wm H McFarland, M.D.

M. D. or other

Address Keyser W. Va Date signed 10-24-46

RECEIVED
OCT 25 1946
BUREAU V

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (49-2)

09648

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 11 yrs.
 Hospital, institution, or street address where death occurred:
129 Greene St.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 129 Greene St.
 (If rural, give LOCATION)
 2.(a) if veteran, name war

3. (a) FULL NAME

Cora Ethel Simons

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

B. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Nov. 28, 1899

8. AGE:

Years

Months

Days

If less than one day

46

10

7

hrs. min.

9. Birthplace

Near Cumberland, Bedford County, Md.

(Town, county, and state)

10. Usual occupation

Housework

11. Industry or business

FATHER

12. Name

Henry W. Simons

13. Birthplace

Bedford Valley, Pa.

MOTHER

14. Maiden name

Mary L. Rice

15. Birthplace

Bedford Valley, Pa.

16. Informant

Mrs. Charles Cole

Address 208 Maryland Ave. Cumberland, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Oct. 8, 1946
(month) (day) (year)

Cemetery or crematory

Hillcrest Burial Park

Location

Cumberland, Md.

18. Funeral director

Charles L. George

Address

Cumberland, Md.

19. Oct. 8, 1946

(Date rec'd by registrar)

J. P. Franklin, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 5, 1946 at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 1, 1946 to Oct 5, 1946
and that I last saw her alive on Oct 5, 1946

Immediate cause of death

Metastases to liver
& peritoneum
Carcinoma of ovaries

DURATION

8-10 mo.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Intestinal Obstruction
(Colostomy)

Date of op. Dec 1/45

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

A. J. Minkin, M.D.
Address 115 S. Centre St. Date signed Oct 7/46

RECEIVED

OCT 15 1945

BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 51c

CERTIFICATE OF DEATH

Reg. Dist. No. 096426

1. PLACE OF DEATH:

County AlleghenyCity or town Cresaptown
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 30 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County AlleghenyCity or town Cresaptown
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2. (a) If veteran, name war World War II

3. (a) FULL NAME

Leroy Wallace Lindy

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Catherine Crites

7. Birth date of

deceased (mo., day, yr.)

Aug 31, 1915

6. (c) If alive, give age

27 years

8. AGE:

Years

31

Months

1

Days

20

If less than one day

hrs.

min.

9. Birthplace

Ridgely, Mineral Co. W. Va
(City, county, and state)

10. Usual occupation

Spinner

11. Industry or business

Celanese Corp

12. Name

John Lindy

13. Birthplace

Moorefield, W. Va

14. Maiden name

Pearl Gray Snyder

15. Birthplace

Cresaptown, Md.

16. Informant

John Lindy

Address

Cresaptown, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Oct 23, 1946
(month) (day) (year)

Cemetery or crematory

Hillcrest Cemetery

Location

Cumberland, Md.

18. Funeral director

John J. Hafey

Address

Aspenburyland, Md.

19. (Date rec'd by registrar)

10/23/46

19

W. W. Vannatta
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 21 19 46 at 3:20 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 1 19 46 to Oct 21 19 46and that I last saw him alive on Oct 21 19 46

Immediate cause of death

Emphysema of Lungs

DURATION

2 years

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Emphysema of Lungs Date of op. March 1, '46

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

W. W. Vannatta M. D. or otherAddress 88 Green St. Date signed 10-23-46

RECEIVED
OCT 16 1992
BUREAU V.B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09650

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County... AlleganyCity or town... Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:

Allegany Hospital, Cumberland, MarylandHow long in hospital or institution? 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... AlleganyCity or town... Corriganville
(If outside city or town limits, write RURAL and give nearest town)Street No. Ellerslie Road
(If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (a) FULL NAME

BETTY LEE SMITH

3. (b) Social Security Number

220-10-94374. Sex F. 5. Color or race W. 6. (a) Single, married, widowed, or divorced S.

6. (b) Name of husband or wife.....

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) January 28, 19218. AGE: Years 25 Months 8 Days 3 It less than one day
..... hrs. min.9. Birthplace... Maryland
(Town, county, and state)10. Usual occupation... Secretary11. Industry or business Celanese12. Name Millard M. Smith13. Birthplace Maryland14. Maiden name Grace Clauson15. Birthplace Maryland18. Informant Allegany HospitalAddress 215 Decatur St., Cumberland, Md.17. Burial Oct. 4, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or place of burial Rose HillLocation Cumberland, Md

Harvey H. Zeigler

18. Funeral director Hyndman, Pa.

Address

19. Oct. 3, 1946 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 1, 1946 at 3 P. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Sept 23, 1946 to Oct 1, 1946
and that I last saw him alive on Oct 1, 3 PM 19. 46Immediate cause of death Meningitis, Chronic DURATION 3 mos.Due to Cause unknown. Refer to University Hospital Records Baltimore, Maryland.
Neurosurgical service under Dr. J. H. Arnold
Other conditions none University Hosp.

(Include pregnancy within 3 months of death)

Major findings of operations.....

..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE RW Trevasakis, Jr. M.D.
M. D. or otherAddress 220 Balto. Ave. Cumberland Date signed 10-3-46
Md.

MARGIN RESERVED FOR BINDING

VS A15 9-45-13

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

OCT 8 1946

BUREAU V A

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Within corporate limits
DR. WILSON

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 122-6

CERTIFICATE OF DEATH

Reg. Dist. No. 09651 40

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution? 2 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town FROSTBURG
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

MRS. HELEN SMITH

3. (b) Social Security Number

none

4. Sex

FEMALE

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

MARRIED

6. (b) Name of husband or wife JAMES H. SMITH

6. (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) DECEMBER 22, 1900

8. AGE: Years 45 Months 10 Days 7 If less than one day
hrs. min.9. Birthplace MARYLAND
(Town, county, and state)

10. Usual occupation HOUSEWIFE

11. Industry or business

12. Name JOHN LAVIN

13. Birthplace Maryland

14. Maiden name Rebecca Folk

15. Birthplace Maryland

16. Informant MEMORIAL HOSPITAL

Address CUMBERLAND, MD.

17. Burial Date thereof Nov. 3, 1946
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory St. Michaels

Location Frostburg md

18. Funeral director J. J. Alirst

Address Frostburg, md.

19. Oct. 31, 1946 J. P. Frankel, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH OCT. 29, 1946 12:50 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
OCT. 27, 1946 to OCT. 29, 1946

and that I last saw her alive on OCT. 29, 1946

Immediate cause of death obstetrical mechanical

Died from obstructed labor

Died from

Died from

Died from

Died from

Died from

Died from

Died from

Died from

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RECEIVED
NOV 6 1946
BUREAU

2-35-

Outside of
City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 191-6

CERTIFICATE OF DEATH

★ 09652 4
Reg. Dist. No.

1. PLACE OF DEATH:

County Allegheny
City or town Mason Road near Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 years

Hospital, institution, or street address where death occurred:
R-7-D-3 Cumberland Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Pa County Cumberland
City or town Carlisle
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Simon Raphael Smith

3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

Gene Baker

6.(c) If alive, give age 24 years

7. Birth date of deceased (mo., day, yr.)

Oct 26, 1856

8. AGE:

Years 89

Months 11

Days 12

If less than one day _____ hrs. _____ min.

9. Birthplace

Carlisle, Cumberland Co., Pa
(Town, county, and state)

10. Usual occupation

Blacksmith

11. Industry or business

Own Business

FATHER

12. Name

Simon S. Smith

13. Birthplace

Germany

MOTHER

14. Maiden name

Eliza Weybeck

15. Birthplace

Germany

16. Informant

Mrs. Fred Galdstein

Address

R-7-D-3 Box 260 - Cumb. Md.

17.

Burial
(Burial, cremation, or removal. Which?)

Date thereof Oct 11, 1946
(month) (day) (year)

Cemetery or crematory

St. Patrick's Cemetery

Location

Carlisle Pa

18. Funeral director

John J. Hofer

Address

Cumberland Md.

19.

Oct. 10, 46
(Date rec'd by registrar)

J.P. Franklin M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 8, 1946 at 2:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 7 to Oct 8 1946

and that I last saw him alive on Oct 7 1946

Immediate cause of death Wrenia Cornu

DURATION

2 day

Due to

Heart - chronic

3 yr

Due to

Organic heart disease

3 yr

Other conditions

old age

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op. _____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Thos. H. Hofer

M. D. or other

Address

Cumberland Md

Date signed 10/11/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

OCT 15 1946

BUREAU V S

Outside of
City Limits

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore 922
CERTIFICATE OF DEATH

09653

Reg. Dist. No. 4

1. PLACE OF DEATH:
County Allegany
City or town Altoona, Cumberland Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Celanese Corp. of Am.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Allegany
City or town Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 603 Williams Street
(If rural, give LOCATION)
2.(a) If veteran, name war.

3. (a) FULL NAME Charles J. Soethe
3. (b) Social Security Number 214-07-1712

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married
6. (b) Name of husband or wife Margaret Price
7. Birth date of deceased (mo., day, yr.) May 1, 1877 8. (c) If alive, give age _____ years
8. AGE: Years 69 Months 5 Days 13 If less than one day _____ hrs. _____ min.

MEDICAL CERTIFICATION
20. DATE OF DEATH Oct. 14 19 46 at 8.35A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19 _____ to _____ 19 _____
and that I last saw him alive on Dead Oct 14 19 46

Immediate cause of death Chronic endocarditis
DURATION several years
Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

9. Birthplace Cumberland Ind.
(Town, county, and state)
10. Usual occupation Carpenter's Helper
11. Industry or business _____
FATHER 12. Name Frederick Soethe
13. Birthplace Germany
MOTHER 14. Maiden name Anna Muthy
15. Birthplace Unknown
16. Informant Mrs. Louis Martin
Address Cumberland
17. Burial Date thereof Oct 17 '46
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory St Peter & Pauls Cem
Location Cumberland
18. Funeral director Louis Martin Inc
Address Cumberland
19. Oct. 16 19 46 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

Major findings of operations _____ Date of op. _____
Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____
Where did injury occur? _____ (City or town) _____ (County) _____ (State)
Injured at home, farm, industry, public place (where?) _____
Means of injury _____ Injured at work? _____
23. SIGNATURE H. V. Deming M.D. H. V. Deming M.D.
M. D. or other _____
Address Cumberland Md Date signed Oct 18/46
Deputy Medical Examiner - Allegany Co.

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

OCT 22 1946

BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-2

CERTIFICATE OF DEATH

096544
Reg. Dist. No.

1. PLACE OF DEATH:

County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Now long in above place of death?

Hospital, institution, or street address where death occurred:

Fort Cumberland Hotel
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County allegany
City or town Frostburg
(If outside city or town limits, write RURAL and give nearest town)
Street No. 81 W. Main St.
(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME

Martha Washington Stern

3. (b) Social Security Number

None4. Sex 5. Color or race W. 6. (a) Single, married, widowed, or divorcedFemale Jewess Single

6. (b) Name of husband or wife.

7. Birth date of deceased (mo., day, yr.) Feb 22, 1879 6. (c) If alive, give age.....years8. AGE: Years Months Days If less than one day
67 7 12hrs.min.9. Birthplace Frostburg Allegany Co., Md
(Town, county, and state)10. Usual occupation Business Woman11. Industry or business Own Business12. Name Bernard Stern13. Birthplace Hungary14. Maiden name Ida Weiner15. Birthplace Baltimore, Maryland16. Informant Soraine EisenbergAddress 823 Windsor Road, Cumberland Md17. Burial Date thereof Oct 6, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory East View CemeteryLocation Cumberland Md18. Funeral director John J. HoyerAddress Cumberland Md19. October 6, 1946 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 4, 1946 at 7 P. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 5, 1944 to October 4, 1946
and that I last saw him alive on September 26, 1946Immediate cause of death Cerebral Hemorrhage (left) DURATION 5 min.Due to HypertensionCardiovascularRenal Disease 12 years

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Samuel Jacobson M. D. or otherAddress W. S. Hoyer Date signed 10/5/46

RECEIVED

OCT 15 1946

BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 462

CERTIFICATE OF DEATH

09655 4
Reg. Dist. No.

DR. ENFIELD

1. PLACE OF DEATH:

County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 DAY

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITALHow long in hospital or institution? 1 DAY

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County ALLEGANYCity or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)Street No. 58 BOONE ST.
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

MR. HUGO A. TASCHENBERGER

3. (b) Social Security Number

705-05-4539

4. Sex

MALE

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

MARRIED6. (b) Name of husband or wife GERTRUDE MOORE6. (c) If alive, give age 65 years7. Birth date of deceased (mo., day, yr.) OCT. 15, 18798. AGE: Years 67 Months 0 Days 5 If less than one day
.....hrs.min.9. Birthplace GERMANY
(Town, county, and state)10. Usual occupation PIPE FITTER11. Industry or business B. & O. Shops12. Name CARL TASCHENBERGER13. Birthplace GERMANY14. Maiden name KAUMER, Agusta15. Birthplace GERMANY16. Informant MEMORIAL HOSPITALAddress CUMBERLAND, MD.17. Burial Date thereof Oct. 22, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Hillcrest Cem.Location Cumberland, Md.18. Funeral director Charles L. GeorgeAddress Cumberland, Md.19. Oct 22 1946 J.P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH OCT. 20 1946, at 6:45 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 19 1946 to Oct 20 1946and that I last saw him alive on Oct 19 1946Immediate cause of death Acute intestinal obstruction

DURATION

Due to Acute intestinal obstructionDue to Acute intestinal obstruction

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) (City or town) (County) (State)

Means of injury Injured at work?

23. SIGNATURE J.P. Franklin M. D. or otherAddress Cumberland Date signed 10/24/46

RECEIVED
OCT 30 1946
BUREAU V

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

09656

CERTIFICATE OF DEATH

Reg. Dist. No. 1

1. PLACE OF DEATH:

County AlleghenyCity or town Oldtown
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 32 yearsHospital, institution, or street address where death occurred: 1

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County AlleghenyCity or town Oldtown
(If outside city or town limits, write RURAL and give nearest town)Street No. Route 1
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Jay Teter

3. (b) Social Security Number

None

4. Sex <u>M</u>	5. Color or race <u>W</u>	6. (a) Single, married, widowed, or divorced <u>Married</u>
--------------------	------------------------------	--

6. (b) Name of husband or wife Lena Hyre Teter7. Birth date of deceased (mo., day, yr.) May 21 1873
6. (c) If alive, give age 68 years

8. AGE:	Years	Months	Days	If less than one day
	<u>73</u>	<u>4</u>	<u>19</u>	hrs. min.

9. Birthplace Pendleton Co., W. Va.
(Town, county, and state)10. Usual occupation Farmer11. Industry or business Own farm12. Name Jacob S. Teter13. Birthplace Pendleton Co., W. Va.14. Maiden name Sadie E. Lantz15. Birthplace Pendleton Co., W. Va.16. Informant Clarence TeterAddress Rt. 1, Oldtown, Md17. Burial Date thereof October 13 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Oldtown Methodist CemeteryLocation Oldtown, Md18. Funeral director John J. HefnerAddress Cumbersburg, Md19. Oct 12 1946 Wm A Shankoltz
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 10 1946 at 2:10 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 10 1946 to Oct 10 1946 and that I last saw him alive on Oct 8 1946Immediate cause of death intercerebral hemorrhageDue to hypertensionDue to hypertensionOther conditions hypertension

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Signature Clarence TeterAddress Cumbersburg, Md33. SIGNATURE Wm A Shankoltz M. D. or otherAddress Cumbersburg, Md Date signed 10-12-46

DURATION

6 weeks

RECEIVED

OCT 17 1946

BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1642)

09657



CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH:

County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred.

Memorial Hosp.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Garrett
 City or town Shang Run
 (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Baby Boy Thomas

3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

October 30, 1946-8:10a

6. (c) If alive, give age

years

8. AGE: Years Months Days If less than one day

14 hrs. 30 min.

9. Birthplace

Cumberland Allegany Co. Md.
(Town, county, and state)

10. Usual occupation

None

11. Industry or business

12. Name

William Thomas

13. Birthplace

Maryland

14. Maiden name

Iris Sines

15. Birthplace

Maryland

16. Informant

Memorial Hosp.

Address

Cumberland Md.

17. Cremation

Oct 30 46 Date thereof (month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Memorial Hosp.

Location

Cumberland, Md.

18. Funeral director

Same as above

Address

Oct 30 46 J. P. Traublin, M.D. Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH

October 30, 1946 at 10:40 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

30 Oct 1946 to 30 Oct 1946and that I last saw him alive on 30 Oct 1946

Immediate cause of death

Coronary Fetal AbnormalitiesDue to perinatal

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

injured at work?

23. SIGNATURE

Fuller B. Minton, M.D. M. D. or otherAddress 112 Bedford St Date signed 30 Oct 46

MARGIN RESERVED FOR BINDING

VS A15

9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2-35-

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 117-2

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County Allegheny
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 45 yrs
 Hospital, institution, or street address where death occurred:
616 Balto. Ave
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md County Allegheny
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 616 Balto. Ave
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

Charles Marshall Twigg

3. (b) Social Security Number

212-18-1349

4. Sex Male 5. Color or race white 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Daisy May Rice
 6. (c) If alive, the age 65 years
 7. Birth date of deceased (mo., day, yr.) April 3, 1877
 8. AGE: Years 69 Months 6 Days 16 If less than one day

8. Birthplace Near Oldtown, Allegheny Co., Md.
 (Town, county, and state)
 10. Usual occupation Laborer
 11. Industry or business Odd Jobs
 12. Name Adam Twigg
 13. Birthplace Near Oldtown, Md.
 14. Maiden name Jemimah Twigg
 15. Birthplace Near Oldtown, Md.

16. Informant Elmer G. Twigg
 Address 616 Balto Ave - Cumberland
 17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Oct 21, 1946
 (month) (day) (year)
 Cemetery or crematory Mt Pleasant Methodist Ch
 Location Near Cumberland, Md

18. Funeral director John J. Hafer
 Address Cumberland, Md.
 19. Oct. 21, 1946 J. P. Tankler, M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 19 19 46, at 6:40 AM
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1944 to Oct 1946 and that I last saw him alive on Oct 1946
 Immediate cause of death Myocarditis, Chronic
Pneumo-pneumonia
 DURATION 1 yr 3 wks
 Due to
 Due to
 Other conditions Severe Secondary Anemia 6 wks
Post Operative Peptic Ulcer 6 wks
 (Include pregnancy within 3 months of death)
 Major findings of operations Ruptured Peptic Ulcer
Hells Massachusetts 6 wks ago
not done Date of op.
 Autopsy results not done
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE R. W. Hewes, Jr., M.D.
220 Balfour Ave M. D. or other
Cumberland Address Date signed 10/19/46

RECEIVED
OCT 30 1946
BUREAU V L

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Reg. Diat. No.

Address..... Date signed.....

RECEIVED
OCT 30 1946
BUREAU V.M.

DR. A. JONES

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (11-2)

09660

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANYCity or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITALHow long in hospital or institution? 17 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County ALLEGANYCity or town NORTH BRANCH
(If outside city or town limits, write RURAL and give nearest town)Street No. Near Cumberland, R.F.D. #4
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

MR. PERRY O. WAGONER (Wagoner)

3. (b) Social Security Number

None

4. Sex

MALE

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

-SINGLE Widowed

6. (b) Name of husband or wife

Virginia Wagoner

7. Birth date of

deceased (mo., day, yr.)

11-6-1873

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

721116

hrs.

min.

9. Birthplace

WEST VIRGINIA

(Town, county, and state)

10. Usual occupation

UNEMPLOYED

11. Industry or business

FATHER

12. Name

JOSEPH WAGONER

13. Birthplace

W. Va.

MOTHER

14. Maiden name

ELLAN SMITH

15. Birthplace

W. Va.

16. Informant

MEMORIAL HOSPITAL

Address

CUMBERLAND, MD.

17.

(Burial, cremation, or removal. Which?)

Date thereof. Oct. 25, 1946

(month) (day) (year)

Cemetery or crematory

Hillcrest Cem.

Location

Cumberland, Md.

18. Funeral director

Charles L. George

Address

Cumberland, Md.

19.

(Date rec'd by registrar)

19. 46J. P. Franklin, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH OCT. 22 19 46 at 4:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct. 4 19 46 to Oct. 22 19 46and that I last saw him alive on Oct. 21 19 46

Immediate cause of death

Pulmonary embolismDue to Thrombophlebitis (unrecognized)Due to Senility

Other conditions

Pneumonia

(Include pregnancy within 3 months of death)

DURATION

3 wks

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Arthur F. Jones, M.D.

M. D. or other

Address 110 S. Centre St. Date signed 10-22-46

RECEIVED
OCT 30 1946
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore **B1-a**

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County AlleghenyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 75 yrs.

Hospital, institution, or street address where death occurred:

216 Davidson St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleghenyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 216 Davidson St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Lucy Virginia Walker

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

David Walker

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

March 14 1853

8. AGE:

Years

Months

Days

If less than one day

9375

hrs.

min.

9. Birthplace

Jefferson Pa.
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

at home

FATHER

12. Name

John Eitzenburg Pa.

13. Birthplace

MOTHER

14. Maiden name

Catherine Jenkins Pa.

15. Birthplace

16. Informant

Miss Martha Walker

Address

Cumberland Ind

17. Burial

(Burial, cremation, or removal, Which?)

Date thereof

Oct 17 '46
(month) (day) (year)

Cemetery or crematory

Rose Hill Cem.

Location

Cumberland

18. Funeral director

Louis Stein Inc

Address

Cumberland

19. Oct 16 '46

(Date rec'd by registrar)

46

J. P. Franklin, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 14 1946 4:45 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct. 8, 1946 to Oct. 10, 1946

and that I last saw him..... alive on..... 19.....

Immediate cause of death

Uræmia

Due to

Chronic interstitial nephritis

Due to

Duration: 5 years

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

..... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Clayton Jones M. D. or otherAddress Cumberland Date signed 10-15-46

RECEIVED

OCT 22 1946

BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County allegany
 City or town Zenithburg - Hoffman mine
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Robert Walsh

3. (b) Social Security Number

none

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

widowed

6. (b) Name of husband or wife

Amelia Walsh

7. Birth date of deceased (mo., day, yr.)

Feb. 16 - 1867

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

79911

hrs.

min.

9. Birthplace

Zenithburg - alleg - md.
(Town, county, and state)

10. Usual occupation

retired

11. Industry or business

rubber worker

FATHER

12. Name

James Walsh

13. Birthplace

Zenithburg, md.

MOTHER

14. Maiden name

Ellen Arnold

15. Birthplace

Zenithburg, md.

16. Informant

Mrs. Luther Yeiden

Address

Zenithburg, md.

17.

(Burial, cremation, or removal Which?)

Date thereof

Oct 30 - 1946
(month) (day) (year)Cemetery or ~~cemetery~~Lakeview

Location

absent Ohio

18. Funeral director

J. J. Quay

Address

Zenithburg, md.

19.

(Date rec'd by registrar)

10-28-46

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State md County allegany
 City or town Zenithburg - Hoffman mine
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH October 27 19 46 at 5 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb. 10 19 46 to Oct. 27 19 46and that I last saw him alive on October 26 19 46

Immediate cause of death

Carcinoma of Stomach

DURATION

2 yrs.

Due to

Senility

Due to

Arterio Sclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

J. C. Diehl, M.D.

M. D. or other

Address

Zenithburg, Md

Date signed

10/28/46

RECEIVED
OCT 31 1946
RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *B7C*

CERTIFICATE OF DEATH

★ 09663

Reg. Dist. No. *4*

DR. WHITWORTH

1. PLACE OF DEATH:

County *ALLEGANY*City or town *CUMBERLAND*
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

*MEMORIAL HOSPITAL*How long in hospital or institution? *11 days*

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *WEST VIRGINIA* County *MINERAL*City or town *KEYSER*
(If outside city or town limits, write RURAL and give nearest town)Street No. *681 W. PIEDMONT ST.*
(If rural, give LOCATION) ✓

2.(a) If veteran, name war

3. (a) FULL NAME

Margaret Ann.
~~BABY GIRL WERNICK~~

3. (b) Social Security Number

None

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

*FEMALE**WHITE**SINGLE*

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.) *OCT. 10, 1946*

8. AGE:

Years

Months

Days

If less than one day

11

hrs.

min.

9. Birthplace

MARYLAND

(Town, county, and state)

10. Usual occupation *NEW BORN*

11. Industry or business

FATHER

12. Name *LESTER WERNICK*13. Birthplace *MARY AND*

MOTHER

14. Maiden name *MARY JANE FELIER*15. Birthplace *W. VA.*16. Informant *MEMORIAL HOSPITAL*Address *CUMBERLAND, MARYLAND*17. *Burial*
(Burial, cremation, or removal) Which?Date thereof *Oct 22, 1946*
(month) (day) (year)Cemetery or crematory *Ches. Cemetery*Location *Westport, Md.*18. Funeral director *Edgeworth & Boal*Address *111 Church St. Westport, Md.*19. *Oct. 22* 19 *46*
(Date rec'd by registrar)*J. P. Franklin, M.D.*
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *OCT. 21, 1946* 19 *46*, at *7:28 P.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

10 Oct 1946 to *21 Oct 1946*and that I last saw her alive on *21 Oct 1946*

Immediate cause of death

*Hydrocephalus**Spinae Bifida**Congenital Anomaly*

Due to

Due to

Other conditions

Bilateral Club feet

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Douglas B Whitworth
M. D. or other *MD*Address *112 Bedford St.* Date signed *21 Oct 46*

RECEIVED
OCT 30 1946
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 9rd

CERTIFICATE OF DEATH

 09664
 Reg. Dist. No. 80

1. PLACE OF DEATH:

County AlleganyCity or town Lonaconing
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Railroad St.

How long in hospital or institution?

3. (a) FULL NAME

Elizabeth Love White

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widow6. (b) Name of husband or wife James White7. Birth date of deceased (mo., day, yr.) Sept. 22, 1870

6. (c) If alive, give age..... years

8. AGE:	Years	Months	Days	If less than one day
	<u>76</u>	<u>1</u>	<u>3</u>	hrs. min.

9. Birthplace Lonaconing-Allegany-Md.
(Town, county, and state)10. Usual occupation House-wife11. Industry or business Own-Home12. Name Charles Ross13. Birthplace Not known14. Maiden name Janet Stevenson15. Birthplace Scotland18. Informant Mrs. Leroy FrantzAddress Westernport, Md.17. Burial Date thereof Nov. 3, 46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Oak-Hill Cem.Location Lonaconing, Md.18. Funeral director Ellsworth S. BoalAddress Westernport, Md.19. Nov 7 19 46 Jannette M Boal
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County AlleganyCity or town Lonaconing
(If outside city or town limits, write RURAL and give nearest town)Street No. Railroad St.
(If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 31 19 46 at 7P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 24 19 46 to Oct. 31 19 46
and that I last saw him alive on Oct. 14 19 46Immediate cause of death Endocarditis

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Henry H. Hodgson Jr. M. D. or otherAddress Lonaconing Md. Date signed Nov 1 '46

RECEIVED
NOV 8 1946
BUREAU

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09665

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1. Hour
 Hospital, institution, or street address where death occurred:

Memorial Hospital
 How long in hospital or institution? 1. Hour

3. (a) FULL NAME

William Blaine
Baby Boy Wilkins

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) October 7, 1946
 6. (c) If alive, give age _____ years

8. AGE: Years Months Days If less than one day
1 hrs. _____ min.

9. Birthplace Cumberland, Allegany Co., Maryland
 (Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Blaine Wilkins
 13. Birthplace Clarksburg, W. Va.

14. Maiden name Angela Fisher
 15. Birthplace Cumberland, Md.

16. Informant Blaine, Wilkins
 Address 441 Furnace St., Cumberland, Md.

17. Burial Date thereof 10/9/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Hill Crest Cemetery
 Location Cumberland, Md.

18. Funeral director William H. Kight
 Address Cumberland, Md.

19. Oct. 9, 1946 J. P. Franklin, M.D.
 (Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 441 Furnace Street
 (If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH October 7, 1946 19 46 at 3-22 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 7, 1946 to Oct. 7, 1946
 and that I last saw him all on Oct. 7, 1946

Immediate cause of death Edema
Maternal toxemia.

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results None
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE W. Royce Hodges
Cumberland, Md. M. D. or other _____
 Address _____ Date signed 10/8/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

OCT 15 1946

BUREAU V S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH:

County Allegany
 City or town Westernport, rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany
 City or town Westernport - rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Norma Jean Wilkinson

3. (b) Social Security Number

4. Sex Female 5. Color or race white 6.(a) Single, married, widowed, or divorced single
 6.(b) Name of husband or wife
 6.(c) If alive, give age years
 7. Birth date of deceased (mo., day, yr.) 27 October 1946
 8. AGE: Years Months Days If less than one day
14 hrs. min.

9. Birthplace Franklin-Allegany-Maryland
 (Town, county, and state)
 10. Usual occupation
 11. Industry or business
 12. Name Parker Wilkinson
 13. Birthplace Nikep, Maryland
 14. Maiden name Alice M. Sullivan
 15. Birthplace West Virginia

16. Informant Parker Wilkinson
 Address Franklin, Md.

17. burial Date thereof Oct 29, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Morrisons Cemetery
 Location Reynolds, Maryland

18. Funeral director Ellsworth Boal
 Address Westernport, Md.

19. October 29, 1946 Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 27 1946 at 7:30p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/27/46 1946 at 10/27/46
 and that I last saw him alive on 10/27/46 1946

Immediate cause of death toxaemia of pregnancy
 Due to
 Due to
 Other conditions
 (Include pregnancy within 3 months of death)

Major findings of operations
 Date of op.

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE [Signature] M. D. or other
 Address Westernport, Md. Date signed 10/29/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 31 1946
BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-2

CERTIFICATE OF DEATH

Reg. Dist. No.

09667

4

1. PLACE OF DEATH:

County... Allegany
 City or town... Flintstone
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?... 76 years
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Ind County... Allegany
 City or town... Flintstone
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mrs Cora Elma Wilson

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Francis R. Wilson

7. Birth date of deceased (mo., day, yr.)

Feb 28, 1870

6. (c) If alive, give age... years

8. AGE:

Years

Months

Days

If less than one day

7677

hrs.

min.

9. Birthplace

Flintstone, Allegany Co. Ind.
(Town, county, and state)

10. Usual occupation

Housework

11. Industry or business

At Home

FATHER

12. Name

John M. Davis

13. Birthplace

Flintstone Ind

14. Maiden name

Julia Robinson

15. Birthplace

Flintstone Ind.

16. Informant

W. F. Dellinger

Address

141 Polk St - Cumberland Ind

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof... Oct 7, 1946
(month) (day) (year)

Cemetery or crematory

Hillcrest Cemetery

Location

Cumberland Ind

18. Funeral director

John J. Hafer

Address

Cumberland Ind.

19. (Date rec'd by registrar)

Oct. 7, 1946

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... Oct 5 1946, at 7:30 AM

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from

July 10, 1945, to October 5, 1946
and that I last saw him/her alive on October 4, 1946

Immediate cause of death

congestive heart failure

DURATION

Due to

12 year atherosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:

Accident, suicide, or homicide... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Polishek & King M.D.
Long, IndDate signed... 10/7

RECEIVED
OCT 12 1945
HONOLULU A

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1600

CERTIFICATE OF DEATH

Reg. Dist. No. 4

09668

1. PLACE OF DEATH:

County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Cresaptown Md
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2. (a) if veteran, name war _____

3. (a) FULL NAME

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) Oct 15 1946 6. (c) If alive, give age _____ years8. AGE: Years _____ Months _____ Days 2 If less than one day _____ hrs. _____ min.9. Birthplace Cumberland Md
(Town, county, and state)

10. Usual occupation _____

11. Industry or business _____

12. Name Alvin B. Winters13. Birthplace Md14. Maiden name Holice Friend15. Birthplace Md16. Informant Alvin B. WintersAddress Cresaptown Md17. Buried Date thereof Oct 21/46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Hillcrest Burial ParkLocation Cumberland Md18. Funeral director Garis Thier IncAddress Cumberland Md19. Oct 21 1946 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-18-1946 21. 123821. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-18-1946 to 10-18-1946and that I last saw him alive on 10-18-1946Immediate cause of death Myocardial InfarctionDue to precipitated labor

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results myocardial infarction

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE L. H. Harris M.D.Address 59 Greene St. Date signed 10-18-46

MARGIN RESERVED FOR BINDING

VS A15

9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In certificate age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 30 1946
BUREAU V.E.